Supreme Court, U
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No. ———

In the Supreme Court of the United States

PAMELA D. COWELL, M.D.,
Petitioner,

v.

GOOD SAMARITAN COMMUNITY HEALTH CARE; GOOD SAMARITAN SURGERY CENTER; CECIL SNODGRASS, M.D.; MICHELLE WATERLAND, R.N.; BRET LAMBERT, M.D.; CARRIE WONG, M.D.; ELIZABETH LIEN, M.D.; KEVIN TAGGART, M.D.; MAUREEN SMITH, M.D.; ROBERT WRIGHT, M.D.; EXECUTIVE COMMITTEE OF GOOD SAMARITAN HOSPITAL; BOARD OF DIRECTORS OF GOOD SAMARITAN HOSPITAL; and DOES A-Z,
Respondents.

On Petition for Writ of Certiorari to the Court of Appeals of Washington, Division 1

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1.

In *McDonald v. City of Chicago*, 561 U.S. ____ (2010), this Court applied an historical test to hold that the right to bear arms for self-defense is a fundamental right that applies to the States through the Fourteenth Amendment, and overruled precedents to the contrary decided before the Court developed its present substantive due process doctrine. The Court also said that it would not single out some fundamental rights for specially unfavorable treatment, and that fundamental rights apply in the same way to the States as to the federal government.

Is the right of trial by jury in suits at common law preserved by the Seventh Amendment a fundamental right under *McDonald*'s holding that applies to the States through the Fourteenth Amendment, and that is, therefore, protected by the Fourteenth Amendment from infringement by the States?

2.

Are this Court's instructions for reviewing the record on a motion for summary judgment in *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986) and its progeny constitutional constraints imposed by the Seventh Amendment, and does, therefore, the Fourteenth Amendment require state courts to review the record to decide motions for summary judgment consistent with this Court's directives?

3.

Did the court below err by reviewing Petitioner's evidence opposing Respondents' motion for summary judgment based on the Health Care Quality Improvement Act in a manner inconsistent with *Anderson* and this Court's other precedents?

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OPINIONS BELOW

The Washington Court of Appeals' decision in *Cowell v. Good Samaritan*, affirming summary judgment and holding Respondents immune under the Health Care Quality Improvement Act (HCQIA), 42 U.S.C. § 11111(a), is reported at 225 P.3d 294 (Wash. Ct. App. 2009), and reproduced at App. A.

The Washington Superior Court's Order, entered July 11, 2008, granting defendants' motion for summary judgment, is reproduced at App. B.

The Washington Supreme Court's decision, denying Petition for Review on July 6, 2010, is reproduced at App. C.

JURISDICTION

The Washington Supreme Court denied Petition for Review on July 6, 2010. Therefore, this petition is timely filed under Supreme Court Rule 13.1, and this Court has jurisdiction pursuant to 28 U.S.C. § 1257(a).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The relevant constitutional provisions are the Seventh Amendment, and Section 1 of the Fourteenth Amendment, to the U.S. Constitution, which are reproduced at App. D, 45a. They provide:

Seventh Amendment:

> "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved..."

Fourteenth Amendment, Section 1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Relevant sections of the HCQIA, the federal statute involved, are reproduced at App. D, 46a-49a. The standards that must be met for immunity to attach under section 11111(a)(1) are set forth in section 11112(a), App. D, 48a-49a, which provides:

> (a) In general.
>
> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken--
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,

> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) unless the presumption is rebutted by a preponderance of the evidence.

STATEMENT OF THE CASE

I. BACKGROUND ISSUES

The Seventh Amendment preserves the right "that questions of fact in common law actions shall be settled by a jury, and that the court shall not assume directly or indirectly to take from the jury or to itself such prerogative". *See Walker v. N.M. & S. Pac. R.R. Co.*, 165 U.S. 593, 596 (1897); *accord Baltimore & C. Line v. Redman*, 295 U.S. 654, 657 (1935) ("substance of the common law right of trial by jury" is to have facts "determined by the jury under appropriate instructions from the court"). Fed R. Civ. P. 56 cannot be interpreted or applied in a way that interferes with

this right. Fed. R. Civ. P. 38 (Seventh Amendment right to jury trial "is preserved inviolate").

This Court has said that to decide a motion for summary judgment courts should not adopt versions of facts "blatantly contradicted by the record". *Scott v. Harris*, 550 U.S. 372, 380 (2007). Courts must review the entire record but believe the evidence of the non-moving party, and only such evidence of the moving party as a jury would be *required* to believe, *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Reeves v. Sanderson Plumbing Prod. Inc.*, 530 U.S. 133, 151 (2000), and afford the non-moving party the benefit of every inference to which he or she is entitled based on the facts in the record. *Hunt v. Cromartie*, 526 U.S. 541, 552 (1999). If "reasonable minds could differ as to the import of the evidence", summary judgment would be improper. *See Anderson, supra*, at 250-51. However, the Court never expressly said that these principles of review were constitutionally compelled by the Seventh Amendment.

Petitioner's law suit arose from termination of her hospital privileges by Respondents on April 17, 2007. Respondents are immune under the HCQIA from damages from related common law actions if the termination met the standards of section 11112(a), App. 48a-49a.

Section 11112(a) creates a rebuttable presumption that these standards were met, and, therefore, that Respondents are immune. However, Petitioner can rebut this presumption by producing sufficient evidence from which a jury could reasonably conclude, by a preponderance of the evidence, that the termination failed to meet one of the standards of

section 11112(a), App. 48a-49a. *See Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1333 & 1334 n. 9 (10th Cir.1996).

The court below disregarded and disbelieved the evidence Petitioner adduced to rebut the presumption that termination of her privileges was reasonable under § 11112(a)(4) and fair under § 11112(a)(3). The court mischaracterized material testimony, and affirmed summary judgment based on a verison of facts "blatantly contradicted by the record". *Scott*, *supra* at 380.

Petitioner contends that by reviewing the record in this way, the court below denied her the right to have a jury decide facts supported by competent evidence, which is preserved by the Seventh Amendment. Petitioner further contends that because the right preserved by the Seventh Amendment is fundamental, it is incorporated into the Fourteenth Amendment, and cannot be infringed by state courts applying their own procedures.

II. BACKGROUND FACTS

Good Samaritan Hospital (GSH), located in Puyallup, Washington, hired Petitioner, a board certified/recertified obstetrician-gynecologist (Ob-Gyn), and other female Ob-Gyns, to compete with Ob-Gyns on its medical staff who were all self-employed and male, but Petitioner left GSH and entered private practice in nearby Lakewood. Petitioner moved her practice back to Puyallup in 2001, because the hospital in Lakewood was closing its obstetrical unit, and became the only female Ob-Gyn in private practice in the area. Petitioner's cases were reviewed relentlessly

thereafter, notwithstanding that they all had good outcomes, and Petitioner, unlike some of her peers, was not an outlier on quality outcome indicators. App. 148a.

Petitioner's cases were not reviewed like those of her peers. Her cases were re-reviewed multiple times, App. 135a, 145a-146a, designated "Room For Improvement" for trivial reasons, and reclassified in the medical staff office as "Standard Not Met". App. 156a. A bogus statistic was thus created in Petitioner's files, and later cited in the report of an Investigating Committee (IC), that Petitioner failed to meet accepted standards in her care of nine patients. A Hearing Committee (HC) determined that all the allegations about these nine cases "lacked a substantial factual basis", and "no substantial factual basis was presented to [the HC] that [Petitioner] did not meet the standard of care, or otherwise behaved inappropriately in such cases". App. 56a, ¶ 1. These findings were withheld from the Medical Executive Committee (MEC), App. 61a, and the Board of Trustees (Board). App. 130a, ¶ 3 (omitting that HC found that allegations lacked a substantial factual basis); *see also* court's opinion at App. 9a (same).

The termination of Petitioner's privileges originated in a Request for Corrective Action (RFCA) by Dr. Snodgrass, Chairman of the Peer Review Committee (PRC), on March 3, 2006. App. 105a. The RFCA was based on allegations about two cases, M526729 & M536099, that two different HCs

determined "lacked a substantial factual basis".[1] App. 7a, ¶ 3, 56a, ¶ 2 & 3. These findings were also withheld from the MEC, App. 170a-171a, and Board. App. 107a, ¶ 2, 5. A four-month investigation ensued that violated many provisions of GSH's bylaws, and culminated in a recommendation by the IC to terminate all Petitioner's hospital privileges, which the MEC accepted on August 7, 2006 without independent investigation.

Dr. Bret Lambert, President of the Medical Staff, selected the members of the IC but did not inform the IC that it was appointed to investigate the allegations in a RFCA, and the IC did not investigate them. App. 164a, 183a. Instead, the IC reviewed a table compiled by the head of the medical staff office, Colleen O'Brien, App. 157a, that summarized select aspects of past reviews and criticisms of Petitioner's cases, 90a-93a, but O'Brien did not provide the IC with all the relevant information and documents about these reviews or their findings. *See e.g.* App. 166a-168a, 179a, 181a, 183a.

For example, O'Brien's table stated that Petitioner performed an operation in 2002 designated "LAVH"[2] when she did not have privileges to perform this procedure, App. 91a, but omitted the fact that Petitioner performed the LAVH with Dr. Michaelson, who did have privileges to perform LAVHs, and that Dr. Eun, the Chairman of Ob-Gyn, determined that

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[1] M526729 was referred to as the Abscess case, M536099 as the Placenta or C-Section case.

[2] Laparoscopically assisted vaginal hysterectomy.

Petitioner had practiced within the scope of her privileges when he subsequently recommended her for reappointment to the GSH medical staff in March, 2003. App. 92a, 94a. This statement, and others in O'Brien's table, appear to have prompted the IC to investigate brand new allegations that were not the basis of the RFCA, but that were ultimately the ones used to justify Petitioner's termination.

The IC did review the medical records of M526729 & M536099, and the HC determined that the IC's criticisms of these cases, like Dr. Snodgrass' allegations in the RFCA, lacked a substantial factual basis. App. 56a, ¶ 2 & 3. This information was withheld from the MEC, App. 61a, the Board, App. 107a, ¶ 5, and the court's opinion. App. 9a, ¶ 2.[3] However, these criticisms spanned less than one page of the IC's 18-page, single spaced report, and the IC's main attack on Petitioner's clinical competence was based on her treatment of a third and new patient, referred to as the Jehovah's Witness case or JW, which occurred three weeks after the IC's investigation should have been completed.

The IC devoted nine pages of its report to criticizing Petitioner's treatment of JW but the second HC determined that all the criticisms lacked a substantial factual basis. App. 57a, ¶ 1.[4] This information, like the findings about all the previous cases, was withheld from the MEC, App. 61a, the Board, App 107a, ¶ 5,

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[3] The court mentioned only the first HC's findings. App. 7a, ¶ 3.

[4] The only criticism the HC credited was that Petitioner dictated JW's operation late.

and the court's opinion. App. 9a, ¶ 2. Dr. Don Russell, a member of the MEC, testified that had he known that all the allegations about Petitioner's clinical practice were found to lack a substantial factual basis, he would not have voted for termination. App. 159a; *compare* App. 26a, ¶ 3 (omitting Dr. Russell's testimony that he would not have voted for termination).

The IC's most serious criticism was that JW was in shock, and everyone except Petitioner recognized this. In fact, no one claimed JW was in shock, and the HC rejected this allegation, and all other allegations concerning JW, as lacking a substantial factual basis, and determined that excessively rapid administration of the narcotic, Fentanyl (by nurse Waterland, App. 177a), had caused JW's blood pressure to fall in the recovery room:

> "there is no substantial factual basis for the finding that the patient was in shock... that was unrecognized by [Petitioner]. Administration of 200 micrograms of Fentanyl over a very short period of time appears to have played a substantial role in the development of the patient's hypotension." App. 57a, ¶ 3.

> "[Petitioner] met the standard of care...there was not a substantial factual basis for the [IC] finding that [Petitioner's] use of the tenaculum caused a potentially life threatening vaginal wall and uterine artery laceration, that she failed to recognize a severe life-threatening complication... that she recommended sending the patient home with hot packs...". App. 60a, ¶ 4.

A. Evidence that termination was unreasonable under section 11112(a)(4).

Petitioner's privileges were ultimately terminated based on brand new allegations first made by the IC during its investigation - that Petitioner had exceeded the scope of her surgical privileges by performing four LAVHs when she did not have privileges to perform LAVHs, and failed to cooperate with peer review by "disregarding" requests to videotape her laparoscopic procedures. Petitioner presented the following evidence to prove that these new allegations were not true, and, therefore, that the termination of her privileges was unreasonable under § 11112(a)(4):

1. Evidence that Petitioner did not exceed the scope of her surgical privileges

(a) No one had ever previously alleged that Petitioner had exceeded the scope of her surgical privileges. App. 143a-144a, 174a, 186a. The IC first made this allegation during its investigation into a RFCA that was not based on this allegation. App. 169a. Nor was this allegation based on newly discovered facts. The IC simply reinterpreted partial, third-hand information in O'Brien's table about events it neither fully understood nor investigated. App. 164a-168a, 173a-174a (p 80), 182a-183a (p 83). *See also* App. 71a-72a.

(b) Petitioner performed the four LAVHs under the supervision of Dr. Michaelson because Dr. Kornberg, Chairman of Surgery, had asked Petitioner to provide more documentation of her experience with LAVHs

before he would credential her for these procedures. App. 63a.[5]

(c) Petitioner proved that Dr. Michaelson was more than an "assistant", and took responsibility for each LAVH, would have intervened had Petitioner performed anything incorrectly, and that the patients were exposed to no greater risk than had they been his patients. App. 151a-152a. Dr. Michaelson's affidavit testimony, *id.*, "blatantly contradicted" the court's characterization of his role in the LAVHs as that of an observer, App. 15a, ¶ 2 ("She relies on evidence showing that she performed the four LAVHs in the presence of Dr. J. Michaelson...").

(d) Dr. Smith, a member of the IC, and Dr. Rose, a member of the HC, both conceded that a physician on the GSH medical staff who did not have privileges to perform procedures for which they had privileges could perform those procedures with them. App. 168a.[6]

(e) Maureen Guzman, GSH's former Director of Quality Management, corroborated the testimonies of Drs. Smith and Rose, and testified that, based on Dr. Michaelson's role in the LAVHs described in his affidavit, Petitioner did not exceed the scope of her privileges by performing these LAVHs with Dr. Michaelson. App. 149a, No. 3. Guzman's testimony

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[5] The LAVHs Petitioner performed in Lakewood were not counted towards her "experience". App. 65a.

[6] Q ...And supposing you had privileges [to do bone marrows] and I did them with you, would I be violating. (sic)
A. No. (Dep. of Rose at 32:21-33:5 filed 6-23-08).

was corroborated by Dr. Sanfilippo, an Ob-Gyn with extensive experience in peer review and credentialing. App. 162a.

(f) Guzman also testified that Dr. Mott, GSH's Vice President of Medical Affairs, performed a knee operation with another physician long after Dr. Mott had relinquished his surgical privileges at GSH, App. 150a, No. 5, indicating that senior hospital administrators were aware that a physician can perform a procedure for which he or she does not have privileges with another physician who does.

(g) Several individuals with a duty to insure that physicians performed only operations for which they had privileges knew that Petitioner was performing these LAVHs with Dr. Michaelson but never prevented her from performing them or informed her that she was not authorized to perform them.

The operating room staff, for example, had a list of every surgeon's privileges, App. 156a, and would have known, when Petitioner scheduled these LAVHs with Dr. Michaelson, that she did not have privileges to perform LAVHs but Dr. Michaelson did, App. 150a, No. 4, and did not prevent Petitioner from performing the procedures.

Drs. Kornberg and Eun both knew that Petitioner had performed the first LAVH with Dr. Michaelson, because both attended the Surgery Committee on June 17, 2002 at which the case was presented. App. 91a. A year earlier, Dr. Kornberg had asked Petitioner to withdraw her request for privileges in LAVHs until she could demonstrate more experience with these procedures, yet neither he nor Dr. Eun informed

Petitioner that she had exceeded the scope of her privileges, or that she was not authorized to do LAVHs even with Dr. Michaelson. On the contrary, after reviewing her reapplication for privileges in 2003, Dr. Eun determined that Petitioner had practiced *within* the scope of her privileges. App. 94a. Attached to the Reappointment Form Dr. Eun signed, was a list of the operations Petitioner had performed during the previous two years, App. 157a (p 23), which would also have informed Dr. Eun that Petitioner had performed this LAVH.

2. Evidence that Petitioner did not fail to cooperate with peer review.

Petitioner presented the following evidence to prove that she also did not fail to cooperate with peer review or comply with requests or directives concerning videotaping her laparoscopic procedures:

(a) No one had ever alleged that Petitioner failed to cooperate with peer review or requests to videotape her laparoscopic procedures before the IC made these allegations. On the contrary, all three former Directors of Quality Management testified that Petitioner had cooperated with peer review. App. 133a, 142a, 154a.

(b) Petitioner proved that nurses, not physicians perform the videotaping, and that there was nothing Petitioner did or failed to do that prevented the hospital from videotaping her laparoscopic procedures. App. 66a-67a.

(c) Petitioner was *asked* to videotape her procedures only once, by Dr. Kornberg in 2001, to facilitate credentialing, after "concerns" were raised

about Petitioner's ostensible lack of familiarity with unspecified laparoscopic procedures and equipment. Petitioner specifically asked the nurses to videotape a procedure but they could not operate the equipment. Petitioner's letter, informing Dr. Kornberg of this fact, was not provided to the IC. App. 166a (p.46), 179a.

(d) Petitioner was never *asked* to videotape her laparoscopic procedures again, directed by the PRC to videotape them or to make arrangements for videotaping, as stated in the HC's report. App. 58a, ¶ 4.

(e) Theresa Young, the operating room manager, was placed in charge of ensuring that Petitioner's laparoscopic cases were videotaped during a four-month review of Petitioner's cases, and two cases were videotaped. This information was withheld from the IC, App. 180a-181a, 183a, and omitted from the HC's report.

(f) In 2005, Petitioner was asked to *agree* to the videotaping of her laparoscopic procedures, App. 95a, which she did, and the only laparoscopic case she performed during this time was videotaped. App. 96a. This information was also disregarded by the IC and HC.

Although the HC credited the IC's new allegations, and recommended that Petitioner's surgical privileges be terminated, the HC disregarded material facts, and justified its conclusions based on factual statements contradicted by the record.

With respect to exceeding the scope of her privileges, for example, the HC disregarded that

Petitioner performed each LAVH with Dr. Michaelson and that Dr. Eun determined that she had practiced within the scope of her privileges, and based its conclusion on the following statements that are not true:

> "On multiple occasions ...[Petitioner] performed surgical procedures exceeding her limited scope of surgical privileges including but not limited to performing non-privileged laparoscopic vaginal hysterectomies." App. 58a, ¶ 3.

Only Petitioner's laparoscopic privileges were ever "limited", however, and she had unrestricted privileges to perform all other types of gynecological procedures. App. 184a (p17) & 185a (p 22). The HC also made no finding that Petitioner had exceeded the scope of her privileges in procedures other than LAVHs.[7] *Accord* 180a (no concerns with petitioner's open [i.e. non-laparoscopic] cases).

With respect to videotaping, the HC disregarded all the foregoing evidence that Petitioner did nothing to prevent the hospital from videotaping her laparoscopic procedures nor failed to comply with any directives concerning videotaping, and based its conclusions concerning this issue on the following statement that was without support in the record:

> "there is a substantial factual basis for the finding that [Petitioner] did not fully discharge

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[7] Q. ...she exceeded the scope of her privileges in one specific operation, didn't she, LAVH; isn't that true?
A Yes. (Dep. of Rose at 28:7-10 filed 6-23-08).

her responsibility to arrange for videotapes of certain surgical procedures, as had been directed by the Peer Review Committee". App. 58a, ¶ 4.

The court did not explain why a jury could not conclude from this evidence that termination of Petitioner's privileges was unreasonable under § 11112(a)(4), and mischaracterized Petitioner's arguments. App. 15a, ¶ 2; *compare* App. 73a-77a & 80a-85a.

B. Evidence that the termination violated section 11112(a)(3).

Petitioner also contended that the termination violated section 11112(a)(3) because the HC's findings and other material information were withheld from the Board (and MEC). App. 72a-73a.

All the information provided to the Board concerning the recommendation to terminate Petitioner's privileges was contained in the report of an Appellate Review Committee (ARC) that considered Petitioner's appeal from the HC's recommendation to terminate her surgical privileges. App. 105a-132a. The ARC's report was drafted by the hospital's lawyers after the hearing before the ARC was concluded,[8] who omitted material information from the report. The ARC's report also asserted "facts" that were neither the findings of any committee nor true. The court simply disbelieved that material facts were withheld

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[8] Documents bearing the footer "SEADOCS" were drafted by Miller Nash. *See* App. 51a-52a.

from the Board, and asserted that Petitioner called and examined witnesses before the ARC. App. 30a, ¶ 3. This was not only untrue, it was "blatantly contradicted" by the appeal process described in GSH's Bylaws that was in the record before the court.

The ARC adopted the report verbatim without verifying its accuracy or completeness,[9] and simply accepted the statements the lawyers had drafted on trust, as, for example, the following evidence and testimony by the Chairman of the ARC indicates:

The ARC's report stated:

> "The evidence in the record is also undisputed that this procedure, LAVH, is considered to be a significantly more advanced laparoscopic procedure than the laparoscopic procedures for which [Petitioner] had privileges." App. 125a, ¶ 3.

The IC's report contains no such statement, the HC made no such finding, App. 185a (p 22), and the following testimony by the ARC Chairman indicates that the ARC accepted the statement as true without verification:

> Q. I mean, that is a factual statement?
> A. Yes.
> Q. Now, what I'm asking you is did somebody write that for you and you relied on their sort of --

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[9] An introduction that recited no facts, App. 100a-103a, and a false claim about the Bylaws, were added.

A. Yes.
Q. And who wrote that for you?
A. I presume it was counsel. (Dep. of David Wold, p. 56:6-18, filed 6-26-08).

Concerning the assertion in the ARC's report that Petitioner refused to take "meaningful responsibility for the issues raised in quality assurance review but took the opportunity to criticize hospital administration, medical staff, and other physicians", App. 128, ¶ 3, the ARC Chairman testified:

Q. This is just a conclusion, isn't it?
A. That's correct.
Q. Right. And I'm just saying to you, is there any basis for that conclusion that you know of?
A. I believed at the time there was.
Q. Believed because somebody wrote this for you and you trusted the person, or meaning you actually saw something with your own eyes?
A. Believed that I trusted what was presented. (*Id.* p. 86:18-87:1).

With respect to statements in the ARC's report that Petitioner exceeded the scope of her privileges on "multiple" occasions with knowing indifference or defiance, App. 125a, ¶ 4-126a, the ARC Chairman testified:

Q. Did you read anything, other than the arguments of counsel, to that effect?
A. Aside from arguments of counsel?
Q. Yes.
A. No.

Q. So it's fair to say...you don't know whether she did it deliberately or not, that's fair, is it?
A. Yes. (*Id.* p. 59:4-13).

The Board accepted the ARC's report as accurate and complete without independent investigation. Therefore, the Board did not know, for example, that Petitioner had performed the LAVHs with Dr. Michaelson; that Dr. Eun had determined that she had practiced within the scope of her privileges; that all allegations about Petitioner's clinical management were found to lack a substantial factual basis; or that the reasons for terminating Petitioner's privileges were not the reasons her privileges were summarily suspended, her cases investigated on multiple occasions in the past, nor the reasons for the RFCA. On the contrary, the ARC's report falsely insinuated that one purpose of the RFCA was to determine if Petitioner practiced within the scope of her privileges. App. 117a, ¶ 2.

The court held that the procedures were fair because they were extensive. App. 28a-29a, ¶ 1. But the court did not explain why withholding from the Board all information favorable to Petitioner, and inconsistent with the hospital's action, was fair. Testimony by one of the three Board members who voted for termination, Mr. Nelson, that the information withheld called into question the termination of Petitioner's privileges,[10] indicates that

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[10] Q..... Do you think that sounds reasonable to you? If all the facts that I've said to you are true, and they are true and they're all documented here.

the information withheld was indeed material, but the court mischaracterized this testimony. App. 28a, ¶ 2.

Similarly, testimony by members of the MEC who attended the MEC meetings at which Dr. Lambert reported the HC findings proved that he concealed these findings from the MEC. For example, Dr. Snodgrass testified that he did not know, and did not believe, that two HCs determined that the allegations he made in his RFCA lacked a substantial factual basis. App. 170a-171a.

The court contradicted this evidence stating,

> "Cowell had the opportunity to challenge Lambert's representations, as summarized in the minutes [of the MEC], before subsequent reviewing panels", App. 26a, ¶ 2.

But this statement is not true. Petitioner first learned of Lambert's misrepresentations - and that the HC reports and hearing records were not provided to the MEC as required by the Bylaws - through discovery in her law suit, long after the peer review was completed.

>

A. If all the facts that you've presented are true, which I don't know for a fact that they are -- then I would say that there is question on the decision, yes. (Dep. of Nelson at p 40, filed 6-23-08) (counsel's objection omitted)

III. DECISIONS BELOW

The trial court, ruling from the bench, granted summary judgment because "Nothing has been shown of any credible evidence that any of this was fraudulent, maliciously done". App. 68a.

The court of appeals affirmed, and held that a jury could not conclude from Petitioner's evidence that the termination was unreasonable or the peer review unfair, but the court disregarded most of Petitioner's evidence, and based its holding on conclusions "blatantly contradicted by the record". *Scott*, 550 U.S. at 380.

A. Sections 11112(a)(1) and (a)(4).

The court considered the reasonableness of the termination only under § 11112(a)(1), App. 14a-20a , and disregarded evidence proving that the termination was unreasonable under § 11112(a)(4). App. 32a; *compare* App. 73a-77a & 80a-85a.[11] Many assertions on which the court based its holding were "blatantly contradicted by the record".

For example, the court disregarded evidence proving that the termination was based on allegations newly contrived during the IC's investigation, and asserted:

> "the record contains abundant evidence of concerns about Cowell's performance of

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[11] The court considered, but dismissed, some of this evidence under § 11112(a)(2). App. 20a-24a

procedures beyond the scope of her privileges and her inability to have her procedures properly videotaped and monitored. In the light of this record, Cowell's claim that such concerns were "shifting justifications for disciplinary action" lacks merit." App. 19a, ¶ 3.

"In sum, the MEC's recommendation and the Board's decision were based on long-standing concerns that Cowell's conduct - namely, her performance of LAVHs without privileges and her failure to comply with videotaping and monitoring requirements - negatively impacted patient care". App. 19a, ¶ 4.

But these assertions of "abundant" and "long-standing" concerns were "blatantly contradicted" by:

1. Testimony of Dr. Taggart, Chairman of the IC:

   Q. And you did not come across, did you, any document, peer review, letters, or anything from anybody suggesting that Dr. Cowell had -- telling her that she had exceeded the scope of her privileges, correct?
   A. Correct. App. 174a. *Accord* App. 186a.

2. Testimony of Maureen Guzman:

   Q. ... Did you hear anyone ever say, in any committee, that Dr. Cowell had exceeded the scope of her privileges?
   A. No.
   Q. Was ever any determination made, while you were there, in connection with her reapplication for privileges, that Dr. Cowell

had practiced outside the scope of her privileges?
A. No. App. 143a-144a

3. Testimonies by GSH's former Directors of Quality Management, Janet Barret, Maureen Guzman, and Dr. Morris, that Petitioner cooperated with peer review. App. 133a, 142a-143a, 154a.

4. Testimony of Dr. Rose, member of the second HC, regarding the claim that Petitioner's allegedly "long-standing" infractions had "negatively impacted patients":

Dr. Rose:	You're asking me if she actually put patients at risk?
Counsel:	Yes.
Dr. Rose:	I don't believe so. (Dep. of Rose at 28:3-6 filed 6-23-08)

The court also based its holding on the following conclusions about the ARC's report:

> "The second ARC report also extensively discussed Cowell's performance of procedures outside the scope of her privileges and her failure to cooperate with the peer review process. It rejected many of the arguments that Cowell raises on appeal." App. 17a, ¶ 4.

These claims are "blatantly contradicted" by the material information omitted from the ARC's report - for example that Dr. Michaelson supervised the four LAVHs and Dr. Eun determined that Petitioner had practiced within the scope of her privileges - and ignore the false statements in the report. *See* App.

122a-126a, § V. The ARC's report "discussed" select violations of the Bylaws, App. 110a-121a, not evidence that Petitioner did not exceed the scope of her privileges or fail to cooperate with peer review. App. 73a-77a & 80a-85a.

The court's assertion that review of Petitioner's cases "raised further questions about her clinical competence and ability to work with others", App. 16a, ¶ 2, was contradicted by the HC's determination that all these "concerns" lacked a substantial factual basis, App. 55a, and that

> "the limited evidence that [Petitioner] had difficult relations with certain nurses and medical providers was offset by testimonials from other nurses and medical providers, as well as patients, extolling [Petitioner's] high quality of care, level disposition and calmness under pressure". App. 59a.

The court's assertion was also contradicted by evidence that almost everyone enjoyed working with Petitioner, App. 136a, 138a-140a, 175a-176a. Even the nurse, whose baseless allegations about the Terbutaline case, App. 55a, ¶ 2, precipitated a four-month review of Petitioner's cases, described Petitioner as "one of the nicest persons [she] had ever met". App. 187a.

Similarly, the court's contention that "The IC's report thoroughly documented this history and expressed these concerns in support of its recommendations", App. 16a, ¶ 3, ignored that these "concerns" were conclusory assertions that lacked a substantial factual basis. For example, the HC

determined that the "concern" that Petitioner "continues to display a pattern of behavior detrimental to her relationships with nurses and other practitioners and thus ultimately to patients" had "no substantial factual basis in the record", App. 59a, and rejected the IC's other "concerns", stating

> "No substantial factual basis was presented to [the HC] on which to find that [Petitioner]... behaved inappropriately with nurses, behaved erratically under stress, or was 'erratic, inappropriate and labile' as the Investigating Committee determined... App. 55a, ¶ 1.

All these findings that the court disregarded were also withheld from the MEC, App. 61a, and the Board. App. 107a, ¶ 5-108a, 130a.

B. Section 11112(a)(2).

The court's contention that

> "The IC further noted that, even if another physician had been in the operating room to watch or assist Cowell, operating on a patient as an attending surgeon without privileges was a violation of the bylaws."

App. 23a, ¶ 1, had no basis in the record. The IC's report contains no such statement, and does not even state that Petitioner performed the LAVHs with Dr. Michaelson.

C. Section 11112(a)(3).

Rather than address the other reasons Petitioner claimed the peer review was unfair, the court shot down arguments Petitioner never made but were imputed to her by the court itself. For example, Petitioner never claimed that the proceedings were unfair because "the first HC differed in its conclusions regarding Cowell's clinical competence". App. 28a, ¶ 2. Petitioner contended that the first hearing was unfair because she was denied adequate notice. App. 70a.[12] Indeed, this is why Respondents did not rely on HCQIA's safe harbor provisions to satisfy § 11112(a)(3). App. 24a, ¶ 2.

Petitioner also never claimed that "the peer review process should resemble formal trial and appellate court proceedings". App. 29a, ¶ 2. On the contrary, Petitioner emphasized the *differences* between these processes at oral arguments in response to the court's false assumptions about GSH's appeals process. App. 86a-89a.

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[12] The first hearing was on the suspension of Petitioner's privileges Dr. Lambert summarily imposed during the investigation. Petitioner proved that the allegations about M526729 & M536099 in the RFCA "lacked a substantial factual basis", and that she did not commit "errors" in her management of JW, but failed to prove that the allegations about JW lacked a substantial factual basis. "She failed to sustain the burden of proof, not that we found proof of error." (Dep. of John Russell at p 8, filed on 6-23-08). However, only Dr. Lambert's allegations about JW were disclosed prior to the hearing. Nurse Waterland and her allegations were not disclosed. App. 51a (identifying witnesses), App. 54a (listing witnesses who testified).

WHY PETITION SHOULD BE GRANTED

The Court should grant Petition to determine if the right to a jury trial in civil cases is a fundamental right protected by the Fourteenth Amendment from infringement by the States, and whether the court below infringed that right. It is one of this Court's paramount duties "to be watchful for the constitutional rights of the citizen, and against any stealthy encroachments thereon". *See. Boyd v. United States*, 116 U.S. 616, 635 (1886). This Court has also said that it would not "single out for...specially unfavorable treatment" a fundamental right. *McDonald v. City of Chicago*, 561 U.S. ____ (2010) (slip op., at 31). The facts of this case frame the legal questions presented with unusual clarity, and, therefore, provide the Court with an ideal opportunity to resolve important legal questions it has not addressed before.

I. THE SEVENTH AMENDMENT RIGHT TO A JURY TRIAL IN CIVIL CASES IS A FUNDAMENTAL RIGHT PROTECTED BY THE FOURTEENTH AMENDMENT FROM INFRINGEMENT BY THE STATES.

Since holding that the Seventh Amendment does not apply to the States directly,[13] this Court has recognized that the due process clause of the Fourteenth Amendment "guarantees more than fair process", *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997), and protects fundamental rights or "liberties" from infringement by the States. The threshold

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[13] See *Minn. & St. Louis R.R. v. Bombolis*, 241 U.S. 211 (1916); *Walker v. Sauvinet*, 92 U.S. 90 (1875).

question here is whether the right to a jury trial in civil cases is among those rights or liberties, and, therefore, applies to the States through the Fourteenth Amendment.

In *McDonald*, decided just last term, the Court emphasized that if a right is fundamental, it is "incorporated" into the Due Process Clause of the Fourteenth Amendment, and that the Court would not single out some fundamental rights for specially unfavorable treatment. *Id.*,__(slip op., at 31). The Court reaffirmed that once a right is "incorporated" the same criteria must be applied to the States as to the federal government to determine if the right has been infringed. *Id.*, at__ (slip op., at 39).

To decide in a principled way whether a right is among the fundamental "liberties" protected by the Fourteenth Amendment, the Court asked whether the right was "fundamental to our scheme of ordered liberty" or "deeply rooted in this Nation's history and tradition", *McDonald* at__(slip op., at 19) (citations and footnote omitted). To answer these questions, the Court looked to "origins in English law...the esteem with which the right was regarded during the colonial era and at the time of the ratification of the Bill of Rights". *See id.*, at__(slip op., at 20-31). Finding that the right to bear arms met this disjunctive test, the Court held that the Second Amendment applied to the States through the Due Process Clause of the Fourteenth Amendment. *Id.*, at__(slip op., at 44-45). Because the Seventh Amendment also meets *McDonald*'s disjunctive test, it is also a due process liberty that should be "incorporated" into the Fourteenth Amendment and applied to the States in

the same manner that it is applied to the federal government.

A. The right to civil jury trials is fundamental to America's scheme of ordered liberty and deeply rooted in its history and traditions.

Americans inherited the fundamental right "preserved" by the Seventh Amendment "that questions of fact in common law actions shall be settled by a jury", *see Walker*, 165 U.S. at 596, through the English common law, which made "extensive use of the jury to provide the court with facts necessary for the decision of a case." *See* A. Hogue, Origins of the Common Law 189 (1966). Although details of civil jury trials have changed over time, the specific right preserved by the Seventh Amendment has remained constant.

For example, so insistent were the "English royal courts...on use of the jury as a means of determining questions of fact" that, to encourage the practice, the Statute of Westminster II (1295) established *nisi prius* courts to allow jurors to determine facts locally so they would not have to travel to Westminster, where the courts of the King's Bench and Common Pleas were located. Hogue, *supra* at 153, 163. Jury trials in civil cases antedated criminal jury trials,[14] and Blackstone not only characterized them as "the glory of the English law" but even implied that the people of Rome,

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[14] Criminal jury trials were largely unknown at the time of Magna Carta (1215). Levy, Origins of the Bill of Rights 212 (1999) (Origins).

Sparta and Carthage lost their liberties because they were "strangers to the trial by jury". W. Blackstone, 3 Commentaries on the Laws of England 379.[15]

American colonists succeeded to the rights of Englishmen through royal and colonial charters. The right to civil jury trials was formally recognized in the Massachusetts Body of Liberties (1641) and in almost every subsequent colonial charter. Schwartz, The Great Right of Mankind: A History of the American Bill of Rights 51 (1992); Levy, Origins, *supra* n.1 at 6-7, 224. By the American Revolution era, "trial by jury was probably the most common right in all the colonies", *see* Levy, *supra* at 226, and when vice-admiralty courts established under the Townshend Acts (1767) enforced the Stamp Act (1765) without juries, colonists asked, "What has America done to be....stripped of so invaluable a privilege as trial by jury?" *See* Brogan, The Penguin History of the United States of America 147 (1985).

After declaring independence, all newly formed states guaranteed the right to trial by jury in civil cases, ten by constitutional guarantees, three by statute or common practice, *Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 341n.4 (1979) (Rehnquist, J., dissenting) (citing to state constitutions), and the right was included in the Northwest Ordinance (1787). *Id.* n.5; Levy, Origins, *supra* n.1 at 227. The right to civil jury trials "as usual" was proposed at the Philadelphia Convention but rejected because variations in state

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[15] Blackstone was "the preeminent authority on English law for the founding generation". *Alden v. Maine*, 527 U.S. 706, 715 (1999).

practices made the term "as usual" difficult to interpret. Levy, *supra* at 228. However, the essence of the right the Seventh Amendment preserves did not vary, only how it was implemented and cases in equity distinguished. *Cosgrove v. Bettin*, 413 U.S. 149, 174 (1973) (Powell, J., dissenting).

According to American revolutionary theory, the right to jury trial was necessary to protect natural rights of "life, liberty and property". Levy, Origins, *supra* at 16. Omission of the right to civil jury trials from the Philadelphia Constitution was a major stumbling block to its ratification. *Parklane Hosiery*, 439 U.S. at 342. Anti-Federalists scoffed at Hamilton's contention that there was no "inseparable connection between the existence of liberty and trial by jury in civil cases", The Federalist Paper (No. 83) 464-65 (Ed. I. Kramnick 1987), by noting that "where there is no trial by jury [government] has an unlimited command over every man who had any thing to lose", and that no one would oppose government "where his property would be wholly at the mercy and decision of those that govern". Levy, Palladium of Justice 93 (1999).

Following ratification, Jefferson suggested to Congress in his inaugural address that "it will be worthy of your consideration, whether the protection of the inestimable institution of juries has been extended to all the cases involving the security of our persons and property."[16] In the *antebellum* period, Abolitionists objected to the enforcement of the

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[16] *See* Thomas Jefferson, First Annual Message, December 8, 1801, available at http://millercenter.org/scripps/archive/speeches/detail/3471.

Fugitive Slave Act (1850) without jury trials because "a claim for a fugitive was a suit at common law that, under the Seventh Amendment, required a jury trial". Curtis, No State Shall Abridge: The Fourteenth Amendment and the Bill of Rights 160 (1986). In 1865, the State Convention of the Colored People of South Carolina specifically requested in a petition to Congress opposing the Black Codes "that we have the right of trial by a jury of our peers".[17]

Those who drafted and adopted the Fourteenth Amendment specifically intended it to overrule *Barron v. Baltimore*, 32 U.S. 243 (1833), and make the first eight amendments in the Bill of Rights applicable to the States. Curtis, *supra* at 155-170, 173l; Aynes, On Misreading John Bingham and the Fourteenth Amendment, 103 Yale L.J. 57 (1993-1994). When the Fourteenth Amendment was ratified in 1868, the right to civil jury trials was protected by 36 of the 37 state constitutions, further indicating the importance attached to civil jury trials. *See* Calebresi & Agudo, Individual Rights under the State Constitutions when the Fourteenth Amendment was Ratified in 1868: What Rights are Deeply Rooted in American History and Tradition? 87 Tex. L.Rev. 7, 50, 77-78 (2008-2009) (opining that failure to incorporate the Seventh Amendment "is quite odd and perhaps mistaken").

Justice Story's 1833 *Commentaries*, reissued in 1873 described the Seventh Amendment as preserving the "inestimable privilege of a trial by jury in civil cases - a privilege scarcely inferior to that in criminal

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[17] *See* http://historymatters.gmu.edu/d/6514 (penultimate paragraph).

cases, which is conceded by all to be essential to political and civil liberty." *See* Wildenthal, The Lost Compromise: Reassessing the Early Understanding in Court and Congress on the Incorporation of the Bill of Rights in the Fourteenth Amendment, 61 Ohio St. L.J. 1051,1146 (2000) (citing 2 Cooley on Story 1873). And since that time, this Court has repeatedly acknowledged the fundamental nature of the right to jury trials in civil cases. *See Teamsters v. Terry*, 494 U.S. 558, 565 (1990) ("Maintenance of the jury as a fact-finding body is of such importance and occupies so firm a place in our history and jurisprudence that any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care'", quoting *Dimick v. Schiedt*, 293 U.S. 474, 486 (1935); *Jacob v. New York*, 315 U.S. 752, 752-53 (1942) ("A right so fundamental and sacred to the citizen... should be jealously guarded by the courts").

It is, therefore, beyond cavil that civil jury trials have deep historical roots, and that Americans have always considered the right fundamental to the ordered scheme of liberty. This conclusion has been reinforced by better understanding of the events in which the Fourteenth Amendment originated, *see generally* Curtis, *supra*; McPherson, Battle Cry of Freedom: The Civil War Era (1988); Foner, Reconstruction: America's Unfinished Revolution (1988), and of this Court's holding in the *Slaughter-House Cases*. *See e.g.* Wildenthal, *supra* at 1135-47 (reviewing nineteenth century case law and refuting suggestions that the Seventh Amendment was a structural right not intended to be incorporated by the drafters).

Civil jury trials do not pose substantial risks to public safety, *McDonald* at__(slip op., at 35-36) (Stevens, J., dissenting), and would ensure that courts treat each individual with equal respect. *Id.* at__(slip op., at 7) (Breyer, J., dissenting). Placing a federal constitutional floor under a right already protected by state constitutions would not interfere with the ability of States to "experiment" with different ways to implement that right, and, therefore, with "federalism". *Id.*, at__(slip op., at 16).

B. The court below denied Petitioner's right to a jury trial.

The court below improperly denied Petitioner's right to a jury trial by crediting Respondents' evidence "over [evidence]...advanced and supported by" Petitioner, *see Hunt*, 526 U.S. at 552; by disbelieving Petitioner's evidence and failing to draw all justifiable inferences in her favor, *Anderson*, 477 U.S. at 255; by basing its holding on factual assertions "blatantly contradicted by the record", *Scott*, 550 U.S. at 380; by mischaracterizing material testimony (of Mr. Nelson, and Drs. Michaelson & Russell); and by failing to consider whether a jury could reasonably find in Petitioner's favor based on the evidence she presented.

The court's decisions did not result from factual error or a refusal to accord marginal evidence arguable inferences. *Shager v. Upjohn Co.*, 913 F.2d 398, 403 (7th Cir. 1990). They were affirmative decisions based on the misconception that the HCQIA changes how courts must review the record on a motion for summary judgment. This misconception stems from a failure to appreciate that the constraints on summary judgment are constitutional, not statutory, and that

Congress had neither the authority nor the intent to require courts to review the sufficiency of evidence presented to oppose a motion for summary judgment based on HCQIA immunity differently from how this Court has instructed courts to review the record to decide motions for summary judgment.

Congress "lacks the power to strip parties contesting matters of private right of their constitutional right to a jury trial", *see Granfinanciera, S.A., v. Nordberg*, 492 U.S. 33, 51-52 (1989), or "to authorize the States to violate the Fourteenth Amendment". *See Saenz v. Roe*, 526 U. S. 489, 508 (1999). Therefore, Congress cannot abrogate a party's right to have factual questions determined by a jury in actions at common law or authorize States to do so. Congress can only withdraw from juries "cases in which the claimant puts forward insufficient evidence to support a verdict", *see Galloway v. United States*, 319 U.S. 372, 373 (1943), since there is no right to have juries decide meritless, frivolous or speculative factual questions.

Nor did Congress intend the HCQIA to work such an effect. The purpose of HCQIA's immunity provisions was "to deter antitrust suits by disciplined physicians". *See Mathews v. Lancaster General Hosp.*, 87 F.3d 624, 633 (3d Cir. 1996). The bill that became HCQIA was introduced in the House Energy and Commerce Committee (HECC), and the balance struck by the HECC between the chilling effect of litigation on peer review and protecting physicians from improper disciplinary actions protected physicians principally from improper anticompetitive conduct, and this is the balance courts have focused on when construing HCQIA. *See Bryan v. James E. Holmes*

Regional Med. Ctr., 33 F.3d 1318, 1322 & n.3 (1994) *cert. denied* 524 U.S. 1019 (1995) ("the bill now provides protection only...for proper peer review", quoting H.R.Rep. No. 903 at 9).

However, two days after H.R. 5540 was voted out of the HECC on September 28, 1986, the Ninth Circuit decided the antitrust case that had caused Congressman (now Senator) Wyden of Oregon to introduce the bill that became HCQIA,[18] and the court described the peer review in that case as "shabby, unprincipled and unprofessional". *Patrick v. Burget*, 800 F.2d 1498, 1509 (9th Cir. 1986) *rev'd on other grounds* 486 U.S. 94 (1988). These findings, and other considerations, engendered significant opposition to the bill's immunity provisions in the House Committee on the Judiciary, after the bill's sequential transfer, because lawmakers on both sides of the political aisle believed that the immunity could be misused to shield illegitimate actions as well as protect appropriate ones.[19]

Several revisions made to H.R. 5540 in response to these concerns by the House Judiciary Committee significantly altered the original balance between chilling peer review and protecting physicians from peer review abuses struck by the HECC. One of the revisions was reduction in the physician's burden to

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[18] *See* Charity Scott, Medical Peer Review, Antitrust, and the Effect of Statutory Reform. 50 Md. L. Rev. 316, 328 (1991) (noting irony that lawmakers used *Patrick* as the principal justification for HCQIA immunity).

[19] 132 Cong. Rec. H9960 (statements of Rep. Edwards); H9964 (statements of Rep. Rodino) (daily ed. Oct. 14, 1986).

rebut the presumption of immunity from the clear and convincing to the preponderance of the evidence standard.[20]

The clear and convincing evidence standard is "reserved to protect particularly important interests". *See California v. Mitchell Bros. Santa Ana Theater*, 454 U.S. 90, 93 (1981). By reducing it to the preponderance of the evidence standard, Congress sent a clear signal that it was as important to avoid falsely accusing physicians of incompetence/unprofessional conduct as to identify incompetent or unprofessional physicians. *Santosky v. Kramer*, 455 U.S. 745, 763 n.13 (1982) ("preponderance-of-the-evidence standard ... is employed... when an incorrect finding of fault would produce consequences as undesirable as...an incorrect finding of no fault"). Reinforcing this clear signal were the repeated and emphatic reassurances of Congressman Waxman, floor manager of the bill, that "Bad faith peer review activities permitted by the Patrick case could never obtain immunity under [HCQIA]".[21]

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[20] *See* H.R. 5110, predecessor of H.R. 5540; 132 Cong. Rec. H11589, cl.3, last para (statements of Rep. Waxman). *See also* 132 Cong. Rec. H11591 (daily ed. Oct. 17, 1986) (explaining another change - addition of subsection E to the original draft of H.R. 5540). App. 49a.

[21] *See* 132 *Cong. Rec.* H11589 (cl.1, last sentence) (daily ed. Oct. 17, 1986). *See also Health Care Quality Improvement Act of 1986: Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 99th Cong., 2d Sess. (Oct. 8 and 9, 1986) at 47, ¶ 2 ("I want to make it clear, however, that we fully agree that we cannot tolerate abuses of the peer review system, and that H.R. 5540 was never intended to protect any such abuses") (statements of Rep. Waxman); Scott, *supra* note 18

Nevertheless, a number of courts, like the court below, have misconstrued the balance Congress struck, have protected abuses of medical peer review against Congress' express contrary intent, and have denied wrongly disciplined, competent physicians their constitutional right to a jury trial. The abuses receiving legal protection are raising growing concern.[22]

The following, unusually forthright concurrence by two justices of the Nevada Supreme Court illustrates these misconceptions and the abuses they have encouraged:

> "I must concur in the result reached in the majority opinion because HCQIA sets such a low threshold for granting immunity to a hospital's so-called peer review. Basically, as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, **whether legitimate or not, they are immune from liability**.

(listing examples of abuses, and noting that Rep. Waxman "frequently took the opportunity to assure the critics that HCQIA was not intended to protect such abuses"). Although anticompetitive and racially motivated actions most concerned lawmakers, they were equally emphatic that actions based on "turf battles", the type of patients treated or the style of practice were equally unacceptable. *Id.* n.61.

[22] *See e.g.* Note: Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of 1986. 111 Penn. St. L. Rev. 104 (2007); Steve Twedt, The Cost of Courage: How the Tables Turn on Doctors, Pittsburgh Post-Gazette, Oct. 26, 2003 available at http://www.post-gazette.com/pg/03299/234499.stm.

> Unfortunately, this may leave the **hospitals and review board members free to abuse the process for their own purposes without regard to quality medical care**. This is particularly probable since most courts have indicated that the legislative history of HCQIA bars consideration of the subjective motives or biases of peer review boards".

See Meyer v. Sunrise Hosp., 22 P.3d 1142, 1149-50 (Nev. 2001) (Shearing, J., joined by Rose, J., concurring) (boldface added).

Although few courts have been as forthright, there are several instances where courts, like the court below, have protected unjustified disciplinary actions against competent physicians based on misconceptions about how the record should be reviewed on a motion for summary judgment based on HCQIA immunity. For example, in *Bender v. Suburban Hosp. Inc.*, 758 A.2d 1090 (Md. Ct. Sp. App. 2000), the court held immune a hospital that had revoked the privileges of a physician who had an "excellent professional reputation", a "legitimate gripe", and who "put patient welfare above all else", "not for want of a wrong", but because "to her misfortune" her claims against the hospital brought "the HCQIA into play", and, "as reprehensible as some of [the peer reviewer's] actions may have been, they succeed as a matter of law".[23]

The present case illustrates that peer review abuses compromise public safety as well as devastate competent physicians professionally and financially.

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[23] See pages 1093, 1100, 1100, 1103 and 1113 for quoted text.

Two deficiencies caused JW's blood pressure to fall in the recovery room: (1) an improper preprinted "range" order for Fentanyl in adults, App. 153a, signed by the Director of the Surgery Center, that did not specify how frequently individual doses of the drug could be repeated, App. 177a; and (2) inadequate nursing instructions on the drug's administration. Yet, when the preprinted orders were revised in August, 2007, App. 99a, eight months after the HC determined that excessively rapid administration of Fentanyl had caused the fall in JW's blood pressure, App. 58a, the deficiency was not corrected, App. 98a, notwithstanding that GSH had already been cited for using improper range orders in the past, App. 143a, and nurse Waterland, who gave the maximum dose of Fentanyl (200 micrograms) over 10 minutes, believed she could have given it even more rapidly - over eight minutes. App. 177a-178a. Manifestly, destroying Petitioner's medical career has not made GSH a safer hospital.

Congress cannot correct the misconceptions that have caused lower courts to shield conduct Congress never intended to protect, or remedy the constitutional violations and social harms they have caused. Only appropriate guidance from this Court can remedy the situation.

CONCLUSION

The petition for review should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

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APPENDIX A

COURT OF APPEALS OF WASHINGTON DIVISION ONE

No. 63845-9-I.

[Filed December 28, 2009]

PAMELA D. COWELL, M.D.,

Appellant,

v.

GOOD SAMARITAN COMMUNITY HEALTH CARE; GOOD SAMARITAN SURGERY CENTER; CECIL SNODGRASS, M.D.; MICHELLE WATERLAND, R.N.; BRET LAMBERT, M.D.; CARRIE WONG, M.D., ELIZABETH LIEN, M.D.; KEVIN TAGGART, M.D.; MAUREEN SMITH, M.D.; ROBERT WRIGHT, M.D.; EXECUTIVE COMMITTEE OF GOOD SAMARITAN HOSPITAL; BOARD OF DIRECTORS OF GOOD SAMARITAN HOSPITAL; and DOES A-Z,

Respondents.

PUBLISHED OPINION

LEACH, J. — Dr. Pamela Cowell appeals the summary judgment dismissal of her claims for damages against Good Samaritan Health Care[1] and various practitioners who participated in the peer review process leading to the suspension and termination of her privileges. She claims to have raised a question of fact about respondents' entitlement to immunity under the Health Care Quality Improvement Act of 1986 (HCQIA or Act), 42 U.S.C. §§ 11101-11152. Cowell also contends that the trial court erred in striking transcripts of her interviews with the Investigation Committee and in awarding attorney fees and costs to respondents. Because Cowell did not present evidence creating a material issue of fact regarding respondents' immunity under the HCQIA, the trial court properly dismissed Cowell's claim on summary judgment. Any error the court may have committed in striking the transcripts is harmless, and no error occurred in awarding fees and costs to respondents. We affirm.

Background

In September 1998, GSH appointed Cowell to the medical staff as an obstetrician and gynecologist. Under the medical staff bylaws, Cowell served as a provisional staff member and was required to apply for renewal of her clinical privileges every two years following her initial appointment. About one year later, Cowell entered into a separation agreement with GSH. She opened her own private practice in

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[1] Good Samaritan Health Care owns Good Samaritan Hospital. The hospital and physicians jointly own Good Samaritan Surgery Center. We refer to these entities collectively as "GSH."

Lakewood but retained her GSH staff membership and privileges.

In May 2000, concerns about Cowell's ability to perform laparoscopic procedures prompted Dr. Jacob Kornberg, chair of the Surgery Committee, to ask Cowell to videotape all of her laparoscopic cases. When Cowell applied for renewal of her privileges in August 2000, Kornberg asked her to revise her application to request privileges only for basic laparoscopic procedures due to her low case load involving more advanced laparoscopic procedures.[2] Cowell reluctantly agreed, and the Board of Trustees (Board) approved her reappointment with privileges to perform only certain laparoscopic procedures.

In 2001, Cowell opened a practice in Puyallup. She admits that on April 12, 2002, as the attending physician, she performed a laparoscopic assisted vaginal hysterectomy (LAVH)-a procedure for which she did not have privileges.

In May 2002, the GSH Obstetrics (OB) Quality Assurance Committee reviewed one of Cowell's cases, the "terbutaline" case, and designated it as "an

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[2] Kornberg warned that failure to make this revision could result in a denial of privileges by GSH that would be reportable to the National Practitioner Data Bank. Kornberg advised Cowell that she could regain these privileges by reapplying for them in the future and then having a preceptor assigned.

opportunity for improvement in clinical care/ management."[3] That same month, Cowell responded to complaints about her performance in the operating room by offering to videotape her more complex surgical procedures.

In August 2002, Cowell was informed that the GSH Medical Executive Committee (MEC) recommended a focused review of her practice from September through December 2002. While this review revealed no adverse outcomes, the Obstetrics and Gynecology (OB/GYN) staff commented that Cowell behaved erratically in stressful situations. The MEC recommended that Cowell receive counseling for stress management. Cowell rejected the recommendation.

In January 2003, Cowell again applied for reappointment, which was approved by the Board. Cowell admits that she later performed three LAVHs, which were still beyond the scope of her privileges, as the attending physician on November 19, 2003, February 6, 2004, and June 11, 2004.

In September 2004, the OB/GYN Quality Assurance Committee reviewed four of Cowell's cases and designated three of them, the "penicillin" case, the "OCT" case, and the "sequestration" case, as opportunities for improvement in clinical care or

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[3] A nurse alleged that Cowell failed to check the dosage of terbutaline given to a patient and argued with nurses about a prolapsed umbilical cord.

documentation.[4] In December 2004, the nursing staff voted Cowell as "Doctor of the Month."

In March 2005, the Board approved Cowell's reappointment, with privileges to perform LAVHs,[5] for six months. A month later, Cowell was notified that five cases, the penicillin, OCT, and sequestration cases, as well as the "ectopic" case and the "impacted head" case,[6] were being sent outside GSH for review.[7] Cowell met with the Peer Review Committee (PRC) to discuss the results of this outside review in August 2005. The PRC recommended to the MEC that all of Cowell's laparoscopic surgeries, except tubal ligations and diagnostic procedures, be monitored by a preceptor and videotaped.[8] These requirements would remain in

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[4] These three cases involved allegations that Cowell failed to note a patient's allergy to penicillin, misused an oxytocin challenge test, and argued with a nurse about the sequestration of an infant from her mother for drug testing.

[5] The Investigation Committee noted in its timeline of events that "[n]o one caught the fact that [Cowell's] laparoscopic privileges were limited."

[6] The ectopic and impacted head cases involved complaints that Cowell was unfamiliar with equipment in performing a laparoscopic excision of an ectopic pregnancy and that she mishandled the delivery of an impacted fetal head.

[7] The external reviewer noted communication issues in all of the cases and questioned Cowell's competence to perform laparoscopic surgery in one case.

[8] The PRC concluded that there was an opportunity for improvement in clinical care in the penicillin, OCT, sequestration, and impacted head cases. In the ectopic case, PRC stated that

effect until the PRC reviewed the successful completion of 10 procedures and notified the MEC. Cowell agreed to these requirements, provided they were not reportable to the National Practitioner's Data Bank (NPDB). In October 2005, the Board renewed her appointment, with privileges to perform LAVHs, for one year.

In March 2006, Dr. Cecil Snodgrass, the PRC chair, submitted a request for corrective action regarding Cowell's clinical practices to Dr. Brett Lambert, the medical staff president and MEC chair. The request focused on two surgical cases, the "abscess" case and the placenta case.[9] The MEC met on March 6, 2006, and, the same day, Lambert notified Cowell that the MEC was appointing an Investigation Committee (IC). Cowell was told that the investigation would not be limited to the abscess and placenta cases and was later informed that the IC's members were Drs. Kevin Taggart, Maureen Smith, and Robert Wright.

In April 2006, Cowell performed a tubal ligation that involved severe bleeding, the "JW" case.[10] Lambert summarily suspended Cowell's privileges on

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clinical care was "not appropriate." Dr. Carrie Wong, an OB/GYN physician, was a member of the PRC.

[9] These cases involved the drainage of a pelvic abscess and an elective caesarian section operation on a patient with an anterior placenta.

[10] The patient, a Jehovah's Witness, would not accept blood transfusions. One of the nurses involved in the JW case was Michelle Waterland. Waterland later testified at the hearing on Cowell's suspension.

April 28, 2006, after speaking with physicians involved in the JW case, reviewing the patient's records, and meeting with Cowell. Cowell was informed that the MEC would review her suspension at its May 1, 2006, meeting, which she was invited to attend. At this meeting, Cowell described her version of events in the JW case. The MEC upheld the suspension and notified Cowell of its decision two days later. Cowell requested and received a hearing on the summary suspension.

About the same time, the IC invited Cowell to discuss the abscess and placenta cases. The IC informed Cowell in its letter of invitation that other cases, including the JW case, might be discussed. The IC also provided Cowell with a list of questions relating to issues that included "the scope of your clinical practice in terms of [your] clinical privileges" and "archiving videotaped cases." The IC also asked for nine videotapes of Cowell's laparoscopic procedures. At Cowell's request, the interview was postponed until June 2006, at which time the IC met with Cowell for nearly three hours. A 90-minute follow-up interview occurred in July 2006. Cowell secretly recorded both interviews and had the recordings transcribed.

The hearing on the summary suspension took place before a Hearing Committee (HC) over four evenings in July 2006. In affirming the suspension, the HC found that Cowell had met her burden of showing that there was no substantial factual basis to support GSH's charges of inadequate care in the abscess and placenta cases. But it found that Cowell had failed to satisfy her burden in the JW case. Cowell requested and received appellate review of the summary suspension.

On July 28, 2006, the IC issued its report. It included findings that Cowell (1) did not "engage cooperatively in the peer review process and ensure appropriate oversight," as demonstrated in the abscess, placenta, and JW cases,[11] (2) failed to comply with her commitments to have her procedures videotaped and monitored, and (3) appeared to have practiced outside the scope of her privileges by performing LAVHs from 2002 to 2005. The IC recommended that the MEC continue the suspension and terminate Cowell's privileges. Cowell received the IC's report on August 2, 2006, and the first HC's report on August 4, 2006.

On August 7, 2006, the MEC met to consider the IC's report. Cowell was allowed 30 minutes to provide a response to the report. Cowell accepted the invitation and read a prepared statement. The MEC voted unanimously to adopt the IC's recommendations.[12] Cowell received notice of the MEC's decision three days later. After being informed of her right to a hearing, she requested one.

Cowell's appeal of the first HC's decision on the summary suspension took place on October 26, 2006. On November 14, 2006, the Board's Appellate Review Committee (ARC) concluded that Cowell had not met the standard of care in the JW case and affirmed the suspension. The Board adopted the ARC's

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[11] The IC concluded that Cowell "likely failed to meet the standard of care" in the JW case.

[12] Dr. Elizabeth Lien, an internist specializing in infectious diseases, was a member of the MEC.

recommendation, and GSH notified Cowell of the Board's decision.

The hearing on the termination was held over the course of seven days in November and December 2006 before a second HC. Nine cases were considered-the terbutaline, penicillin, OCT, sequestration, ectopic, impacted head, abscess, placenta, and JW cases-as well as issues relating to Cowell's cooperation with the peer review process and her performance of procedures outside the scope of her privileges. On December 29, 2006, this second HC issued its report. The HC found no substantial factual basis for the IC's conclusions that Cowell's clinical practices violated the standard of care. But it found a substantial factual basis for the IC's conclusions that Cowell (1) had a "combative history with the peer review process," (2) did not fully carry out her videotaping and monitoring commitments, and (3) exceeded the scope of her privileges. The HC recommended that Cowell's surgical privileges be terminated but her nonsurgical privileges be reinstated.

A second ARC heard Cowell's appeal of the second HC's decision on March 19, 2007. On April 12, 2007, this ARC affirmed the HC's conclusions that Cowell had performed procedures beyond the scope of her privileges and had failed to participate collaboratively in the peer review process. On April 17, 2007, the Board approved the ARC'S recommendation. As required by 42 U.S.C. § 11133(a), the privilege suspension and termination were reported to the NPDB.

Cowell filed suit for damages against GSH and various individuals who had participated in the peer

review process, alleging defamation, tortious interference with her practice, breach of contract, and violations of the Washington Consumer Protection Act, RCW 19.86.020. Cowell also sought to enjoin the revocation of her privileges. Respondents moved for summary judgment and to strike the transcripts of the IC's interviews with Cowell. The court granted both motions. In striking the transcripts, the court ruled that interviews were private conversations under RCW 9.73.030(1)(b). In granting summary judgment to respondents on the damages and injunctive relief claims, the court held respondents were immune under the HCQIA. The court also awarded respondents attorney fees and costs. Cowell appeals the dismissal of her action for damages and the award of attorney fees and costs.[13]

Analysis

A. Immunity Under the HCQIA

The primary question is whether Cowell presented sufficient evidence to raise a factual issue about respondents' entitlement to immunity under the HCQIA. Congress passed this Act "'to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior.'"[14] To

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[13] Cowell does not appeal the trial court's dismissal of her request for injunctive relief under the Washington Health Care Peer Review Act, RCW 7.71.030. She discusses this request only as it relates to the award of attorney fees.

[14] *Morgan v. PeaceHealth, Inc.*, 101 Wash.App. 750, 762, 14 P.3d 773 (2000) (quoting *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624,

promote effective self-regulation by physicians, the Act grants limited immunity from damages to participants in professional peer review actions.[15]

Cowell asserts that respondents are not entitled to HCQIA immunity for three reasons. First, respondents' peer review actions did not satisfy the immunity elements under § 11112(a). Second, various practitioners participating in GSH's peer review process as witnesses and decisionmakers violated § 11111(a)(2) by making statements they knew were false. Finally, GSH violated § 11137(c) by submitting a false report to the NPDB.

1. Immunity Elements under § 11112(a)

Cowell claims that respondents' peer review actions did not meet the immunity requirements of § 11112(a). This statute contains four elements that a professional

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632 (3rd Cir.1996)). Washington has adopted the HCQIA. *See* RCW 7.71.020.

[15] *Morgan,* 101 Wash.App. at 762, 14 P.3d 773 (quoting *Mathews,* 87 F.3d at 632). The HCQIA provides immunity from damages, not from injunctive relief. *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 911 (8th Cir.1999).

review action[16] must meet for its participants to receive immunity:[17]

> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken-
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,

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[16] A "professional review action" is defined as

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges ... of the physician.

42 U.S.C. § 11151(9).

[17] If a professional review action meets the four elements under § 11112(a), a professional review body, any person acting as a member or staff to the body, any person under a contract or other formal agreement with the body, and any person who participates or assists the body with respect to the action, shall not be liable for damages with respect to the action. 42 U.S.C. § 11111(a). A "professional review body" is defined as "a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." 42 U.S.C. § 11151(11).

> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

These four elements are measured by "objective reasonable belief standards," which look to the totality of the circumstances.[18] The Act creates a presumption that a professional review action meets these four elements unless the plaintiff can rebut the presumption by a preponderance of the evidence.[19]

This rebuttable presumption "adds an 'unconventional twist' to the summary judgment standard of review."[20] Although respondents are the moving parties, this court must view the evidence in the light most favorable to Cowell and determine whether she has shown that a reasonable jury could conclude, by a preponderance of the evidence, that respondents' review actions did not meet all four

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[18] *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 32 (1st Cir.2002).

[19] 42 U.S.C. § 11112(a).

[20] *Morgan*, 101 Wash.App. at 766, 14 P.3d 773 (quoting *Sugarbaker*, 190 F.3d at 912).

elements of § 11112(a).[21] Respondents are thus relieved of the initial burden of providing evidentiary support for their motion. Cowell's burden, however, remains similar to the burden faced by any plaintiff confronted with a properly supported motion for summary judgment: to defeat the motion she must raise a genuine issue of material fact as to whether respondents' peer review actions did not satisfy at least one of the § 11112(a) elements.[22]

Applying these principles, we analyze the evidence Cowell relies upon to challenge the MEC's August 7, 2006, recommendations to continue her suspension and terminate her privileges and the Board's decisions affirming the suspension and termination of her privileges. Because the actions regarding termination are dispositive, we focus on these review actions.

a. Reasonable Belief That the Action Was in the Furtherance of Quality Health Care

Since the reasonable belief required by the first element under § 11112(a) is measured by an objective

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[21] *Morgan*, 101 Wash.App. at 766-67, 14 P.3d 773. This summary judgment standard indicates that "a jury could be asked to decide the ultimate issues of reasonableness," but under the objective standards set forth in the statute, reasonableness determinations under the HCQIA may become legal determinations appropriate for resolution at summary judgment. *Singh*, 308 F.3d at 34, 36.

[22] *Singh*, 308 F.3d at 33.

standard, bad faith on the part of the reviewers is irrelevant.[23] [24] [25]

Cowell contends that she met this burden on two grounds. First, she claims that she did not place patients at risk by performing four LAVHs without specific privileges. She relies on evidence showing that she performed the four LAVHs in the presence of Dr. J. Michaelson, who had privileges to perform LAVHs, that the IC and second HC did not find that the LAVHs were significantly more advanced than the laparoscopic procedures for which Cowell did have privileges, that none of the LAVHs had any complications, and that she was granted privileges to perform LAVHs in 2005. Second, Cowell claims that she did not place patients at risk by failing to videotape all of her laparoscopic procedures. She points to evidence demonstrating that videotaping is not an effective method of assessing a physician's surgical skills,[26] that no other gynecologist was asked to videotape his or her procedures, and that the videotapes were never reviewed.

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[23] *Morgan*, 101 Wash.App. at 769, 14 P.3d 773.

[24] *Morgan*, 101 Wash.App. at 769, 14 P.3d 773 (quoting *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1334-35 (11th Cir.1994)).

[25] *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir.1992) (quoting H.R.Rep. No. 903, 99th Cong., 2d Sess. 10, *as reprinted in* 1986 U.S.C.C.A.N. 6287, 6392-93).

[26] Cowell relies on the report of an external reviewer, Dr. Joseph S. Sanfilippo.

These arguments are misdirected because they focus on whether Cowell actually harmed patients and whether respondents' actions actually improved health care. But "the HCQIA is not limited to review actions taken in response to patient injury."[27] Furthermore, "the Act does not require that the professional review result in an actual improvement of the quality of health care[,] [only that] the process was undertaken in the *reasonable belief* that quality health care was being furthered."[28]

Concerns about Cowell's ability to perform advanced laparoscopic procedures such as LAVHs arose as far back as May 2000. She was asked to videotape her procedures at that time, and restrictions were placed on her privileges in August 2000. Behavioral issues surfaced in 2002 when a focused review of Cowell's practice led to MEC's recommendation that Cowell receive counseling for stress management, which Cowell declined. From 2002 to 2006, internal and external reviews of Cowell's cases raised further questions about her clinical competence and ability to work with others and reinforced placing restrictions on her privileges and oversight measures of her practices.

The IC's report thoroughly documented this history and expressed these concerns in support of its recommendation to the MEC that Cowell's privileges be terminated. The report concluded that Cowell "has

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[27] *Morgan*, 101 Wash.App. at 768, 14 P.3d 773.

[28] *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir.1994).

engaged in a pattern of disregarding commitments she has made to have procedures videotaped, has performed procedures outside the scope of her privileges, and has otherwise failed to engage fully and cooperatively in the peer review process." From interviewing Cowell, the IC noted that

> [Cowell] conveyed a lack of recognition of the importance of the peer review process and an unwillingness to participate by neither providing the [video]tapes nor otherwise following through with her agreement to have a preceptor in the operating room. [Cowell] referred to Dr. Michaelson as her preceptor, and states that it would be very difficult for her to find a preceptor on a routine basis. It appears to us that [Cowell] has performed procedures as the attending physician for which she does not have privileges, in violation of Hospital Bylaws, Rules and Regulations.

The IC also reported that on four separate occasions Cowell "appears to have performed [LAVHs] when she did not have privileges to perform this procedure, in violation of the Medical Staff Bylaws." Further, the IC found that Cowell had improperly obtained privileges to perform LAVHs in 2005 without "tak[ing] affirmative steps such as completing additional continuing medical education."

The second ARC report also extensively discussed Cowell's performance of procedures outside the scope of her privileges and her failure to cooperate with the peer review process. It rejected many of the arguments that Cowell raises on appeal. Notably, the ARC rejected Cowell's contention that she misunderstood

the process for obtaining privileges she had voluntarily given up, pointing to Kornberg's letter advising Cowell of the privilege reapplication process and the medical staff bylaws.[29] In affirming the second HC's findings that Cowell had exceeded the scope of her privileges, this ARC stated,

> [T]he evidence in the record establishes that [Cowell] knew the extent of her surgical privileges, knew and acknowledged her personal responsibility for practicing within the privileges granted her by the Hospital, and knew and acknowledged that even the simple surgical procedures for which she had privileges were surgical procedures that placed patients at substantial risk unless expertly performed. Yet, despite this knowledge and these acknowledgments, [Cowell] proceeded on multiple occasions to perform more complicated surgical procedures for which she did not have privileges, placing both patients and the Hospital at risk.

This ARC agreed with the second HC's conclusion that Cowell had a combative history with the peer review process, noting that

> [o]n multiple occasions between 2000 and 2005, [Cowell] was requested to or required to video tape her laparoscopic procedures. She

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[29] Article IV, section 5 of the bylaws states, "To renew or reinstate a privilege that has been voluntarily or involuntarily reduced will require completion of the privilege request and approval process for specific privilege(s) to be renewed."

> consistently failed to obtain the video tapes, citing, as justification for this failure, the inability of nurses to operate the equipment, the failure of a member of the hospital administrative staff to provide for video taping, or her misunderstanding of what procedures were to be video taped.
>
> A physician who will not work collaboratively with the peer review process ... impairs the ability of the medical staff and the hospital to improve the quality of medical care provided to patients.

Thus, the record contains abundant evidence of concerns about Cowell's performance of procedures beyond the scope of her privileges and her inability to have her procedures properly videotaped and monitored. In light of this record, Cowell's claim that such concerns were "shifting justifications for disciplinary actions" lacks merit. The fact that these particular concerns later emerged as the primary reasons for terminating her privileges is not evidence that the MEC and the Board did not reasonably believe that they were furthering quality health care in terminating Cowell's privileges.[30]

In sum, the MEC's recommendation and the Board's decision were based on long-standing concerns that Cowell's conduct-namely her performance of

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[30] *See Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064, 1071 (8th Cir.2005) ("'The fact that some of the specific concerns shifted or changed over time does not rebut the presumption' that the hospital acted in the reasonable belief that it was furthering quality health care.") (quoting *Sugarbaker*, 190 F.3d at 913).

LAVHs without privileges and her failure to comply with videotaping and monitoring requirements-negatively impacted patient care. "'Quality health care' is not limited to clinical competence, but includes matters of general behavior and ethical conduct."[31] Thus, Cowell has not created an issue of fact as to whether reviewers, in the position of members of the MEC and the Board, would reasonably have concluded, based on the information before them, that their actions were necessary to protect patients or restrict incompetent behavior.

b. Reasonable Effort to Obtain the Facts

The relevant inquiry under the second element of § 11112(a) is whether "the totality of the process leading up to the professional review action evidenced a reasonable effort to obtain the facts of the matter."[32]

Cowell's challenge to the actions taken by the MEC and the Board under this element focuses on the adequacy of the IC's investigation in three areas. First, Cowell argues that the IC did not reasonably investigate whether she practiced within the scope of her privileges because the IC failed to review the Surgery Quality Assurance Committee Meeting minutes for June 17, 2002. These minutes state that Kornberg and Dr. Paul Eun, the OB/GYN chair, failed to inform Cowell that she exceeded the scope of her privileges in performing the LAVH on April 12, 2002.

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[31] *Meyers v. Columbia / HCA Healthcare Corp.*, 341 F.3d 461, 469 (6th Cir.2003).

[32] *Morgan*, 101 Wash.App. at 770, 14 P.3d 773.

According to Cowell, Eun further indicated in his reappointment review dated March 27, 2003, that Cowell had practiced within her privileges. Cowell also points to the testimony of Dr. Smith, an IC member, and Dr. Andrea Rose, a member of the second HC. Both stated in their depositions, in response to hypothetical scenarios posed by Cowell's counsel, that a physician without privileges to perform certain procedures, such as "intubations" and "bone marrows" could perform them in their presence since they had those specific privileges.

Second, Cowell argues that the IC failed to reasonably investigate whether she cooperated with the peer review process. She claims the IC was unaware that Cowell had explained to Kornberg in a letter dated August 3, 2000, that the nurses could not work the video equipment, that a hospital administrator was responsible for assuring that all of Cowell's procedures were videotaped during the four-month focused review in 2002, and that the September 2005 agreement did not require Cowell to videotape procedures herself.

Third, Cowell argues that the IC did not reasonably investigate the abscess, placenta, and JW cases, as well as her other past cases because the IC failed to review a consultation note in the abscess case, to question a nurse "in a meaningful way" about the placenta case, to fully "explore" Cowell's explanation in the JW case, and to review patient charts in other past cases.

These arguments fail because Cowell is entitled to "'a reasonable investigation under the Act, not a

perfect investigation.'"[33] Thus, the IC is not required to carry out its investigation in any particular manner; it is only required to conduct a factual investigation that is reasonable under the circumstances. The IC's investigation in this case was extensive. Under the bylaws, the IC, after receiving a request for corrective action, must issue a report of its investigation within 30 days. Here, the IC's investigation lasted approximately four and a half months, as the IC realized during its review of Cowell's voluminous quality assurance and credentialing files that it needed more time and notified Lambert.[34] In addition to reviewing these files, the IC met with Cowell for more than four hours in two interviews to discuss the scope of her practice in terms of her privileges, her compliance with videotaping and monitoring requirements, and her management of the abscess, placenta, and JW cases, as well as other past cases.

The IC made further efforts to investigate these three areas of concern. First, in determining that Cowell had exceeded the scope of her privileges, the IC reviewed Cowell's privilege applications and records of her procedures. From these documents, it concluded that Cowell did not have privileges to perform LAVHs between 2001 and 2005 and yet performed four LAVHs as the attending surgeon during that time period-facts

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[33] *Singh*, 308 F.3d at 43 (quoting *Egan v. Athol Mem'l Hosp.*, 971 F. Supp. 37, 43 (D. Mass.1997)).

[34] The second ARC found the IC acted within the bylaws since Cowell never objected to and was not prejudiced by the duration of the investigation.

conceded by Cowell.[35] The IC further noted that, even if another physician had been in the operating room to watch or assist Cowell, operating on a patient as an attending surgeon without privileges was a violation of the bylaws.

Second, in determining that Cowell had failed to cooperate with the peer review process, the IC noted that she was unable to produce the nine videotapes it had requested. It also traced Cowell's history of failing to produce requested videotapes of her laparoscopic procedures.[36]

Finally, in its investigation of the abscess, placenta, and JW cases, the IC reviewed the patient charts, as well as reports from four outside reviewers retained by Cowell and a report from one outside reviewer retained by the MEC. The IC also spoke with several physicians and nurses with knowledge of Cowell's clinical practice. With respect to other past cases, although the IC did not review patient charts, it examined reviews prepared by various quality assurance/peer review committees.

Cowell has neither shown that reliance on the IC's report by other reviewers in the process was

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[35] Cowell also admitted her personal responsibility for keeping track of the scope of her privileges before the second HC.

[36] Regarding Cowell's argument that the IC exceeded the scope of its authority, the second ARC found the IC acted within the bylaws.

unreasonable[37] nor presented evidence creating an issue of fact that might lead a reasonable jury to conclude that the fact-finding process was unreasonable.

c. Adequate Notice and Hearing Procedures

The third element of § 11112(a) requires that a physician receive adequate notice and procedures or "other procedures as are fair to the physician under the circumstances."[38] GSH can comply with this element in one of two ways. It can comply with the "safe harbor" notice and procedure rules contained in 42 U.S.C. § 11112(b) or it can provide "other procedures as are fair to the physician under the circumstances."[39] Respondents claim to have complied in the second way.

Cowell contends that the procedures were neither adequate nor fair because "material information was withheld from both the MEC and the Board." Before addressing the merits of these arguments, we briefly describe the procedures provided under GSH's medical staff bylaws.

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[37] *Mathews,* 87 F.3d at 638 (stating that reports by a preliminary investigative committee and by an outside reviewer, even though they conflicted with a report prepared by the physician's expert, were "not so obviously mistaken or inadequate as to make reliance on them unreasonable").

[38] 42 U.S.C. § 11112(a)(3).

[39] 42 U.S.C. § 11112(a)(3)

Article IV, section 6 of the bylaws outlines the procedures when a request for corrective action is filed against a physician. Under this section, the president of the medical staff, upon receiving a corrective action request "should notify the practitioner of the specific reasons and request for corrective action." If the request could result in reduction or suspension of privileges, the president must appoint an IC. Before the IC issues its report, the physician "shall have an opportunity for an interview with the [IC]" and before the interview "shall be informed of the specific charges against him and shall be invited to discuss, explain or refute them." This interview "shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply."

Following receipt of the IC's report, the physician is permitted to request an appearance before the MEC. Like an appearance before the IC, this appearance is informal and preliminary in nature. If the MEC recommends termination of privileges, the physician is entitled to the procedural rights in Article IV, section 7 of the bylaws. This section entitles a physician to one hearing before an HC, consisting of three members of the medical staff and a hearing officer, and one appellate review before the Board. The Board may appoint an ARC, composed of at least three Board members, to conduct the appellate review. The bylaws grant the physician the right to representation by an attorney, to call and cross-examine witnesses, and to submit evidence before both the HC and ARC. If appealing to the ARC, the physician may submit written appellate statements concerning "any step in the procedure to which the appeal is related."

Cowell's complaints are directed to the fairness and adequacy of the process she received in connection with the MEC's August 7, 2006, recommendation and the Board's decision to terminate her privileges.

Her complaints regarding the MEC's recommendation lack merit. Cowell contends that the MEC meeting minutes show that Lambert misrepresented the first HC's conclusions. But the minutes do not conclusively demonstrate this. They simply summarize, without quoting, Lambert's report to the MEC. The minutes state that the first HC found that the abscess and placenta cases "by themselves would not warrant continued summary suspension. However, with the addition of the [JW] case ... the summary suspension should be upheld." Even if we assume that these were Lambert's exact words, Cowell had the opportunity to challenge Lambert's representations, as summarized in the minutes, before subsequent reviewing panels.

Cowell also points to the deposition testimony of Dr. Donald Russell, an MEC member who stated that he was unaware that the first HC found no substantial factual basis that Cowell provided substandard care in the abscess and placenta cases.[40] But the fact that the first HC differed in its conclusions regarding Cowell's clinical competence does not establish that the process

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[40] Cowell also appears to argue that Russell was unaware of the second HC's findings. But the second HC's report was issued on December 29, 2006. Russell voted to terminate Cowell's privileges at the MEC's August 7, 2006, meeting.

was unfair.[41] It reflects the independence of the reviewing panels. Moreover, Cowell had the opportunity to present the first HC's findings to the MEC in the time allotted to her.

Finally, Cowell contends that informal review procedures do not satisfy the HCQIA. Case law, however, indicates the contrary,[42] and Cowell fails to cite any authority in support of her position. She further ignores the medical staff bylaws which expressly state that appearances before the IC and MEC are not formal appeal procedures.

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[41] *See Morgan*, 101 Wash.App. at 773, 14 P.3d 773 ("[T]he fact that varying review committees differed on its conclusions does not undermine the fairness of the procedures."); *cf. Singh*, 308 F.3d at 41 ("The reversal of a peer review committee's recommendation of an adverse professional review action by a higher level peer review panel does not indicate that the initial recommendation was made without a reasonable belief that the recommendation would further quality health care."); *Austin*, 979 F.2d at 735 (holding that reversal of a medical executive committee's recommendation by a judicial review committee failed to establish that the defendants did not have a reasonable belief that the suspension was warranted).

[42] *See Morgan*, 101 Wash.App. at 772 n. 4, 14 P.3d 773 (holding that the informal procedures used throughout the review process leading to the revocation of privileges satisfied the adequate notice and procedures element of § 11112(a)(3)); *Singh*, 308 F.3d at 30, 43-44 (holding that procedures were adequate even though the physician did not have the opportunity to challenge the results of an audit before requesting a hearing); *Smith v. Ricks*, 31 F.3d 1478, 1487 (9th Cir.1994) (stating the HCQIA does not require "peer review proceedings to look like regular trials in a court of law.").

In any event, the record shows that Cowell received more than adequate notice and procedures before the MEC recommended terminating her privileges. Cowell was notified that a corrective action request had been filed against her and that the investigation prompted by the request was not limited to the placenta and abscess cases. When the IC was formed, Cowell was informed of the identity of its members. Before each of the IC's interviews, Cowell was provided with a list of questions relating to issues that included the scope of her practice in terms of her privileges and her compliance with videotaping and monitoring requirements. After receiving such notice, Cowell prepared written responses to the IC's questions and submitted reports from four outside reviewers to each IC member. Cowell met with the IC twice. She promptly received a copy of the IC's report, providing her further notice.[43] She was then invited to attend the August 7, 2006 MEC meeting and was given 30 minutes to respond to the IC's report. Under the circumstances, Cowell was given adequate notice and opportunity to be heard before the MEC recommended terminating her privileges.

For similar reasons, Cowell's complaints regarding the Board's decision are unavailing. Cowell cites the deposition testimony of Mr. Mike Nelson, a Board member who stated that he was unaware of favorable findings made by both the first and second HC. As stated previously, the fact that different panels

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[43] In oral argument, Cowell conceded that she had received notice of the charges regarding the scope of her practice and cooperation with the peer review process when she received a copy of the IC's report.

reviewing the case reached different conclusions demonstrates independence-not unfairness-in the review process. Moreover, the record establishes that Cowell had ample opportunity to present the findings of both HCs to the second ARC. In two appellate statements, Cowell discussed both HC's findings and extensively quoted the second HC's findings. Accordingly, the second ARC expressly acknowledged in its report that the second HC had found that there was insufficient evidence to support findings that Cowell provided substandard care. Significantly, the second ARC went on to note that the second HC nonetheless recommended termination of all of Cowell's surgical privileges based on her failure to practice within the scope of her privileges and to cooperate with the peer review process. Cowell's failure to mention this aspect of the second HC's report further undermines her argument that closer examination of this report's findings would have led the Board to a different conclusion.

Cowell repeats her contention that the review process should resemble formal trial and appellate court proceedings. In oral argument, counsel for Cowell compared the Board to an appellate court and stressed that Cowell did not have an opportunity to further challenge the second ARC'S recommendation before it was adopted by the Board. But the Board's delegation of fact-finding does not violate the

requirements of the HCQIA.[44] Indeed, the HCQIA does not require any level of appellate review.[45]

Furthermore, consistent with the bylaws, Cowell received more than adequate notice and procedures before the Board decided to terminate her privileges. After the MEC's recommendation, Cowell was informed of her right to a hearing. She requested and received a hearing before a second HC, comprised of three members of the medical staff and a hearing officer, who was a retired superior court judge. At the seven-day hearing before it, Cowell was represented by counsel, called and cross-examined witnesses, and presented evidence. The second HC stated that it considered the testimony of witnesses at the hearing, prior witness testimony, witness declarations and statements, documentary exhibits, extensive opening statements and closing arguments, and posthearing submissions.

Following the second HC's decision, Cowell was notified of her right to appeal that decision. She requested and received appellate review. Before a second ARC composed of three Board members, Cowell was represented by counsel, called and cross-examined witnesses, and presented evidence. In formulating its recommendation to the Board, the second ARC stated

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[44] *See Bender v. Suburban Hosp., Inc.*, 134 Md. App. 7, 43, 758 A.2d 1090 (2000) ("There is nothing irregular about a high-level reviewing body leaving the detailed fact-finding efforts to a lower-level hearing panel or committee."); *see also Singh*, 308 F.3d at 44; *Smith*, 31 F.3d at 1487.

[45] *Ne. Ga. Med. Ctr., Inc. v. Davenport*, 272 Ga. 173, 176, 527 S.E.2d 548 (2000) (quoting *Sugarbaker*, 190 F.3d at 915).

that it considered the record created before the second HC:

> [T]he Appellate Review Committee is to review the recommendation(s) of the Hearing Committee and to determine whether the decision and recommendation were justified and not arbitrary and capricious. To this end, the Appellate Review Committee reviewed the record created before the Hearing Committee during the fair hearing on the Medical Executive Committee's recommendation of termination of all [Cowell's] clinical privileges at Good Samaritan Hospital. This record consisted of the verbatim transcript of the testimony of the witnesses and the opening statements and closing arguments of counsel for the parties. The record also consisted of the exhibits offered and admitted during the course of the fair hearing.

The ARC further stated that it reviewed two appellate statements submitted by Cowell, a response statement submitted by Lambert, and a rebuttal statement by Cowell. The second ARC also heard oral presentations from both sides. Finally, as required under the bylaws, the second ARC gave equal weight to the MEC's and second HC's recommendations in concluding that Cowell's failure to engage with the peer review process and to practice within the scope of her privileges warranted termination of all privileges.

Cowell has failed to raise an issue of fact as to whether she was provided with notice and procedures that were fair and adequate under the circumstances.

d. Reasonable Belief That the Action Was Warranted by the Facts Known After Such Reasonable Efforts to Obtain Facts and After Adequate Notice and Procedures

Analysis under the fourth element of § 11112(a) closely tracks the analysis under the first element.[46] As discussed above, the MEC's recommendation and the Board's decision to terminate Cowell's privileges were well supported and focused on patient care. The record also establishes that Cowell received adequate notice and procedures in accordance with medical staff bylaws. Cowell did not present evidence creating a material issue of fact as to whether respondents acted with the reasonable belief that termination of her privileges was warranted by known facts.

2. Immunity under § 11111(a)(2)

Cowell contends that respondents Lambert, Snodgrass, Lien, Wong, Waterland, Taggart, Smith, and Wright are not entitled to HCQIA immunity because they provided false information with knowledge of its falsity in violation of § 11111(a)(2). This section provides a separate ground for immunity for these respondents, as it applies to individuals "providing information to a professional review body regarding the competence or professional conduct of a physician ... unless such information is false and the person providing it knew that such information was false." We need not consider whether these respondents are entitled to immunity under § 11111(a)(2) because we have already determined that

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[46] *Morgan*, 101 Wash.App. at 773, 14 P.3d 773.

they are entitled to immunity as either members of a professional review body or individuals assisting a professional review body under the § 11112(a) analysis.[47]

3. Immunity under § 11137(c)

Section 11137(c) provides immunity for any entity that makes a report to the NPDB "without knowledge of the falsity of the information contained in the report." GSH is therefore immune from liability unless "there is sufficient evidence for a jury to conclude the report was false and the reporting party knew it was false."[48]

Here, Cowell claims that GSH should not receive immunity because the NPDB report states that the Board "affirmed the recommendation to terminate physician's privileges based in part on a determination that physician's conduct of practicing beyond the scope of her privileges and non-cooperative approach to the peer review process was detrimental to the health and safety of patients." Relying on *Brown v. Presbyterian Healthcare Services,*[49] Cowell focuses on the phrase "in

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[47] *See Singh v. Blue Cross & Blue Shield of Mass., Inc.*, 182 F. Supp.2d 164, 175 (D. Mass.2001). Moreover, the discrepancies pointed out by Cowell, such as representations made by Lambert to the MEC and by the IC members in their report, are insufficient to establish that these respondents made false statements with knowledge of their falsity.

[48] *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1334 (10th Cir.1996).

[49] 101 F.3d 1324 (10th Cir.1996).

part" and argues that this statement "clearly conveys the false defamatory meaning that Dr. Cowell's privileges were partly revoked because of deficiencies in her clinical care."

Brown, however, is distinguishable. There, a report was made to the NPDB stating that Brown's obstetrical privileges had been suspended for incompetence, malpractice, and negligence.[50] But the peer review panel had suspended Brown for breaching an agreement to obtain appropriate consultation.[51] Neither the review panel nor the hospital Board of Trustees ever found Dr. Brown negligent, incompetent, or guilty of malpractice. Therefore, the record presented sufficient evidence for a jury to find the report was false and the defendant who had made the report knew it was false.[52]

Here, the reasons stated by GSH in support of its decision are the same as those reported to the NPDB. The words "in part" do not make the report false. These two words communicate nothing about Cowell's clinical care. Nor do these words establish that GSH submitted the report with knowledge of its falsity.

B. Ruling on Striking Transcripts

Cowell contends that the trial court erred in striking the transcripts of Cowell's interviews with the IC on grounds that these interviews were private

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[50] *Brown,* 101 F.3d at 1334.

[51] *Brown,* 101 F.3d at 1334.

[52] *Brown,* 101 F.3d at 1334.

conversations within the meaning of RCW 9.73.030(1)(b).[53] Any error the court might have committed in striking the transcripts is harmless since the transcripts raise no question of fact concerning compliance with any of the four elements of 42 U.S.C. § 11112(a).

C. Attorney Fees

Cowell argues that the trial court abused its discretion in awarding fees and costs to respondents for defending against Cowell's claims for injunctive relief under RCW 7.71.030 and for damages under 42 U.S.C. § 11113. We review an award for attorney fees for an abuse of discretion.[54]

Cowell first argues that an award under RCW 7.71.030 was unjustified because she was "merely testing the scope of a statute on which there is no law" and because her request for injunctive relief was only a "small part" of her complaint and amended complaint. Under RCW 7.71.030, "[r]easonable attorneys' fees and costs as approved by the court shall be awarded to the prevailing party, if any, as determined by the court." Accordingly, the trial court awarded respondents, as the prevailing parties, $290,656.50 in fees and $18,888.50 in costs under RCW 7.71.030. The court found Cowell's claims for

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[53] RCW 9.73.030(1)(b) provides, "Except as otherwise provided in this chapter, it shall be unlawful for any individual ... to intercept, or record any ... [p]rivate conversation ... without first obtaining the consent of all persons engaged in the conversation."

[54] *Boeing Co. v. Sierracin Corp.*, 108 Wash.2d 38, 65, 738 P.2d 665 (1987).

damages and injunctive relief relied on "a common core of facts and circumstances." The court also found the time spent on the two separate legal theories that were applied to this common factual core was segregated and that fees related to work on theories on which respondents did not prevail were excluded. Finally, the court found that the amount of time spent by respondents' counsel and the discounted hourly rates at which most of the time was billed were reasonable. The record supports these findings, and RCW 7.71.030 authorizes the award of reasonable fees and cost to respondents. This award included fees incurred developing the common factual core and presenting the legal theories related to the request for injunctive relief only.

Cowell next argues that an award was inappropriate under § 11113 because her HCQIA claims involved questions of first impression and were not frivolous. Under § 11113, a defendant should receive an award of costs and fees when (1) the defendants are persons covered by the HCQIA, (2) the elements under § 11112(a) were met, (3) the defendants substantially prevailed, and (4) the plaintiff's claim or conduct during the litigation was frivolous, unreasonable, without foundation, or in bad faith. Here, the court awarded $69,132.50 in fees and $4,600 in costs under § 11113 because respondents met all of these requirements. In particular, the court held that Cowell's legal arguments that respondents failed to satisfy the elements under § 11112(a) and her decision "to issue hundreds of written discovery requests and to take more than fifty depositions in pursuit of her claims [were] unreasonable." On this

record, we cannot say that the court abused its discretion in awarding fees under § 11113.[55]

Finally, respondents request fees on appeal under RAP 18.1 and § 11113. While respondents have prevailed on appeal, Cowell's appeal is not frivolous, unreasonable, without foundation, or in bad faith. We therefore deny respondents' request.

Conclusion

Cowell did not offer evidence creating an issue of material fact as to whether the actions taken by respondents satisfy the immunity elements under the HCQIA. Accordingly, respondents are immune for suspending and terminating Cowell's privileges. Any error the court may have committed in striking the transcripts is harmless. The court also did not err in awarding fees and costs to respondents.

Affirmed.

Leach, J.

WE CONCUR:

LAU, J

BECKER, J.

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[55] *See Meyers*, 341 F.3d at 473 ("Whether a party's claim or conduct is frivolous, unreasonable, or without foundation is a question committed to the sound discretion of the district court.") (citing *Johnson v. Nyack Hosp.*, 964 F.2d 116, 123 (2d Cir.1992)).

APPENDIX B

Honorable Katherine M. Stolz
Hearing Date: July 11, 2008

SUPERIOR COURT OF WASHINGTON FOR PIERCE COUNTY

Case No. 07-2-05660-8

[Filed July 11, 2008]

PAMELA D. COWELL, M.D.,	)
	)
Plaintiff,	)
	)
v.	)
	)
GOOD SAMARITAN COMMUNITY HEALTH CARE; GOOD SAMARITAN SURGERY CENTER, CECIL SNODGRASS, M.D.; MICHELLE WATERLAND, R.N.; BRET LAMBERT, M.D., CARRIE WONG, M.D.; ELIZABETH LIEN, M.D.; KEVIN TAGGART, M.D.; MAUREEN SMITH, M.D.; ROBERT WRIGHT, M.D.; EXECUTIVE COMMITTEE OF GOOD SAMARITAN HOSPITAL; BOARD OF DIRECTORS OF GOOD SAMARITAN HOSPITAL; and DOES A-Z,	)

Defendants.)
_____)

ORDER GRANTING DEFENDANTS' CR 56 MOTION FOR SUMMARY JUDGMENT AS TO ALL OF PLAINTIFF'S CLAIMS

I. THE HEARING

1. Date. June 27,2008.

2. Judge. The Honorable Katherine M. Stolz.

3. Appearances. Defendants appeared by their attorney, Greg Montgomery of Miller Nash LLP. Plaintiff appeared by her attorney, Nicholas Kadar, M.D.

4. Purpose. To consider Defendants' Motion for Dismissal of Plaintiff's Claims Pursuant to CR 12(b)(6) and CR 56.

5. Evidence. The Court considered:

(a) Defendants' Motion for Dismissal of Plaintiff's Claims Pursuant to CR 12(b)(6) and CR 56;

(b) Declaration of Greg Montgomery and the exhibits thereto;

(c) Declaration of Maureen Smith, MD and the exhibits thereto;

(d) Declaration of Kevin Taggart, MD and the exhibits thereto;

(e) Declaration of Carrie Wong, MD and the exhibits thereto;

(f) Declaration of Bruce Dammeier and the exhibits thereto;

(g) Declaration of Bret L. Lambert, MD and the exhibits thereto;

(h) Declaration of Cecil Snodgrass, MD and the exhibits thereto;

(i) Declaration of Elizabeth Lien, MD and the exhibits thereto;

(j) Declaration of Michele Waterland, RN and the exhibits thereto;

(k) Declaration of Robert Wright, MD and the exhibits thereto;

(l) Declaration of Marc Gaspard and the exhibits thereto;

(m) Declaration of Colleen O'Brien and the exhibits thereto;

(n) Declaration of William Rinker, MD and the exhibits thereto;

(o) First Amended Complaint for Injunction and Damages;

(p) Plaintiff's Brief Opposing Summary Judgment;

(q) Declaration of Pamela Cowell, M.D. in Support of Plaintiff's Brief Opposing Summary Judgment and the exhibits thereto, excluding Exhibits 33 and 34 which were stricken based on defendants' motion to strike;

(r) Declaration of Nicholas Kadar in Support of Plaintiff's Brief Opposing Summary Judgment and the exhibits thereto;

(s) Plaintiff's Correct Brief;

(t) Errata Sheet;

(u) Declaration of Nicholas Kadar in Support of Plaintiff's Corrected Brief and the exhibits thereto;

(v) Defendants' Reply Brief in Support of CR 12(b)(6) and CR 56 Motion to Dismiss Plaintiff's Claims.

(w) Reply Declaration of Greg Montgomery in Support of Defendants' Motion for Summary Judgment;

(x) Declaration of Nicholas Kadar Rebutting Factual Averments Contained in Defendants' Reply Brief and in Support of Plaintiff's Opposition to Defendants' Motion for Summary Judgment.

II. ORDER

On the basis of the foregoing, it is hereby,

ORDERED, ADJUDGED AND DECREED that Defendants' CR 56 Motion for summary judgment as

to all of plaintiff's claims is GRANTED and judgment is hereby entered in favor of defendants on all of plaintiff's claims against all defendants for monetary damages on various legal theories, and for injunctive relief under R.C.W. 7.71.030, pursuant to the immunity provisions of the Health Care Quality Improvement Act of 1986 and the provisions of R.C.W. 7.71.030.

DATED this 11th day of July, 2008.

/s/ Katherine M. Stolz
The Honorable Katherine M. Stolz

Presented by:
MILLER NASH LLP

/s/ Greg Montgomery
Greg Montgomery
WSB No. 7985

Attorneys for Defendants

APPENDIX C

THE SUPREME COURT OF WASHINGTON

No. 84158-6
C/A NO. 63845-9-I

[Filed July 6, 2010]

PAMELA D. COWELL, M.D.,	)
	)
Petitioner,	)
	)
v.	)
	)
GOOD SAMARITAN COMMUNITY HEALTH CARE, GOOD SAMARITAN SURGERY CENTER, CECIL SNODGRASS, M.D., MICHELLE WATERLAND, R.N., BRET LAMBERT, M.D., CARRIE WONG, M.D., ELIZABETH LIEN, M.D., KEVIN TAGGART, M.D., MAUREEN SMITH, M.D., ROBERT WRIGHT, M.D. EXECUTIVE COMMITTEE OF GOOD SAMARITAN HOSPITAL; BOARD OF DIRECTORS OF GOOD SAMARITAN HOSPITAL; and DOES A-Z,	)
	)
Respondents.	)
	)

ORDER

Department I of the Court, composed of Chief Justice Madsen and Justices C. Johnson, Sanders, Owens and J. Johnson, considered at its July 6, 2010, Motion Calendar, whether review should be granted pursuant to RAP 13.4(b), and unanimously agreed that the following order be entered.

IT IS SO ORDERED:

That the Petitioner's motion to strike Appendix A from the Respondent's answer is granted. The Respondent's motion to strike reply to answer is granted. The Petition for Review is denied.

DATED at Olympia, Washington this 6th day of July, 2010.

For the Court

/s/ Madsen, C.J.
CHIEF JUSTICE

589/92

APPENDIX D

U.S. CONSTITUTION, Amend. VII

In suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise reexamined in any court of the United States, than according to the rules of the common law.

U.S. CONSTITUTION, Amend. XIV

Section 1.

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

TITLE 42 — THE PUBLIC HEALTH AND WELFARE

CHAPTER 117 — ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11101. Findings

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

SUBCHAPTER I — PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11111. Professional review

(a) In general

(1) Limitation on damages for professional review actions

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section —

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. § 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. § 1981, et seq. Nothing in this paragraph shall

prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of title 15, where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

* * *

42 U.S.C. § 11112. Standards for professional review actions

(a) In general.

For purposes of the protection set forth in section 411(a) [*42 USCS § 11111(a)*], a professional review action must be taken--

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) *[42 USCS § 11111(a)]* unless the presumption is rebutted by a preponderance of the evidence.

* * *

42 U.S.C. § 11151. Definitions

In this chapter:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

* * *

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or

patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on —

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

* * *

APPENDIX E

MILLER | NASH LLP
ATTORNEYS AT LAW

July 14, 2006
Page 6

* * *

D. Evidence.

In support of the summary suspension action, the following witnesses and documentary evidence will be presented:

1. Dr. Bret Lambert * * *

2. Ginny Johnson * * *

3. Karen Baker * * *

4. Dr. Mize Connor * * *

5. Nancy Milden * * *

6. Documents to be offered include the documents contained in the accompanying three ring binder.

Very truly yours,

/s/ Greg Montgomery
Greg Montgomery

Enclosures

File No.: 523990-0023
Doc ID: SEADOCS:237375.3

APPENDIX F

BEFORE THE HEARING COMMITTEE
AT GOOD SAMARITAN HOSPITAL
PUYALLUP, WA

In the Matter of the Medical Staff Privileges of:	)
PAMELA D. COWELL, M.D.	)

Hearing dates: July 17, 18, 24, and 26, 2006

* * *

CASES AT ISSUE

* * * Therefore there are three cases presented to the hearing panel which can be described as follows:

M-526729 is a case involving a post-vaginal hysterectomy where the patient had complained of abdominal pain and pelvic abscess was found.

M-536099 concerned an elective cesarean section involving an anterior placenta.

M-472458 relates to a tubal ligation of a patient who was a member of Jehovah's Witnesses; post-operative bleeding complications.

WITNESSES

* * *

In support of the summary suspension the following were called on behalf of Good Samaritan Hospital:

* * *

Dr. Bret Lambert, president of the medical staff

Ginny Johnson, labor and delivery nurse at Good Samaritan Hospital

Karen Baker, a nurse at Good Samaritan, working the labor and delivery floor

Dr. Mize Connor, an expert witness who is a practicing OB/GYN in Bellevue, WA

Michelle Waterland, a nurse, Good Samaritan Hospital Surgery Center

Charlyne Taylor, recovery room nurse, Good Samaritan Hospital Surgery Center

* * *

APPENDIX G

BEFORE THE HEARING COMMITTEE
AT GOOD SAMARITAN HOSPITAL
PUYALLUP, WA

In the Matter of the Medical Staff Privileges of:	)
	)
PHYSICIAN 1189	)
	)

Report and Recommendation of the Hearing Committee (Hearing Dates: November 6, 7, 19, 21, and 30; December 11 and 12, 2006)

* * *

No substantial factual basis was presented to this Hearing Committee upon which to find that Physician 1189 threw tantrums, behaved inappropriately with nurses, behaved erratically under stress, or was "erratic, inappropriate and labile," as the Investigation Committee determined.

This Hearing Committee did not find a substantial factual basis for the allegation that in the Terbutaline case Physician 1189 gave a full ampule of terbutaline to the patient or pulled a prolapsed umbilical cord out of the vaginal introitus to show Jean Horner, a Labor and Delivery Nurse

The Hearing Committee does not believe that concerns previously reviewed by Quality Management that were not addressed by the Investigation Committee have a substantial factual basis for purposes of the present report and recommendation. No substantial factual basis was presented to this Hearing Committee that Physician 1189 did not meet the standard of care, or otherwise behaved inappropriately, in such cases. (The specific cases that were addressed by the Investigation Committee are further discussed in the present Report and Recommendations.)

* * *

In the abscess case, this Hearing Committee did not find a substantial factual basis for the Investigation Committee's apparent criticisms of Physician 1189's timing and response to patient care, interaction with medical staff peers, and recognition of sepsis. The Hearing Committee believes that Physician 1189's choice of antibiotics was medically reasonable. Draining the abscess through the use of interventional radiology was not required by the standard of care, and indeed may have involved significant risk absent contrast studies.

In the C-section case, this Hearing Committee did not find a substantial factual basis for the Investigation Committee's concern that the amount of bleeding prior to entry into the uterus suggested practice below the standard of care. * * *

* * *

The Hearing Committee finds that the other findings of the Investigation Committee concerning the Jehovah's Witness case lack substantial factual basis. The evidence does not support the proposition that Physician 1189 pushed forward on this elective procedure demonstrating her lack of clinical judgment. The only direct witness besides Physician 1189 to the placement of the tenaculum was Jack Hammons, Surgery Center Scrub Technician. Mr Hammons stated his observation that Physician 1189 struggled mostly at the beginning of the case when the tenaculum was being placed, but his observations do not support a finding that Physician 1189 did not meet the standard of' care or otherwise acted inappropriately during the initial surgery.

Though Physician 1189 may have caused lacerations to the patient in her attempts to place the tenaculum (the cause of the patient's lacerations was not established), the Hearing Committee believes that she ultimately achieved proper tenaculum placement--otherwise the surgery could not have been completed. In any event, the crux of the Investigation Committee's findings as to the Jehovah's Witness case do not relate to Physician 1189's violation of' the standard of care in tenaculum placement, and this Hearing Committee does not find a sufficient basis in the record for a finding that Physician 1189 did violate the standard of care as to surgical technique.

The Investigating Committee has carefully reviewed the patient's vital signs and other information available to Physician 1189 during the relevant time period and finds that there is no substantial factual basis for the finding that the patient was in shock, whether caused by massive blood

loss from injury to the uterine artery during the first surgery or from another surgical injury, that was unrecognized by Physician 1189. Administration of 200 micrograms of fentanyl over a very short time period appears to have played a substantial role in the development of the patient's hypotension.

In sum, the Hearing Committee finds that there was not a substantial factual basis for a findings that Physician 1189 failed to recognize that the patient was in shock, that Physician 1189 did not appreciate that internal bleeding within the pelvis can be massive and that the patient was experiencing ongoing blood loss, or that Physician 1189 did not demonstrate confidence performing a routine gynecologic procedure or fail to respond to emergent needs of the patient with quick and concise actions.

* * *

The Hearing Committee finds substantial factual basis for the Investigation Committee's finding that Physician 1189 exceeded the scope of her surgical privileges * * *. On multiple occasions over a period of years, Physician 1189 performed surgical procedures exceeding her limited scope of surgical privileges, including but not limited to performing non-privileged laparoscopic assisted vaginal hysterectomies.

Though the evidence on this point is somewhat confused because of issues of responsibility for videotaping and availability of functioning equipment, it also appears to this Hearing Committee that there is a substantial factual basis for the finding that Physician 1189 did not fully discharge her responsibility to arrange for videotapes of certain

surgical procedures, as had been directed by the Peer Review Committee.

* * *

1 Physician 1189 continues to display a pattern of behavior detrimental in her relationship to nurses and other practitioners and thus ultimately to the care of her patients.

The Hearing Committee finds no substantial factual basis in the record for this finding. Further, the limited evidence that Physician 1189 has had difficult relationships with certain nurses and medical providers was offset by testimonials from other nurses and medical providers, as well as patients, extolling Physician 1189's high quality care, level disposition, and calmness under pressure. * * *

* * *

This Hearing Committee finds no substantial factual basis for the finding that Physician 1189 has a pattern of failing to identify and appropriately respond to serious clinical situations. The evidence before this Hearing Committee supports the proposition that Physician 1189 met the standard of practice in all cases as to which specific evidence was introduced.

* * *

* * * While it is true that a physician may fail to meet the standard of care without injuring patients, this Hearing Committee notes that Physician 1189's patients were not shown to have suffered worse than average outcomes, either in the cases under review or

in other cases during the time she has had privileges at GSH.

* * *

As discussed above, this Hearing Committee does not believe that a substantial factual basis exists for a finding that Physician 1189 has failed to identify serious clinical situations, nor is there a reasonable basis for the conclusion that her conduct has endangered patients.

Physician 1189 has had a combative history with the peer review process. A substantial factual basis exists for the finding that Physician 1189 has been unwilling to engage collaboratively in the peer review process.

* * *

* * * Based on the evidence presented to it, the Hearing Committee finds that Physician 1189 met the standard of care. The Hearing Committee finds that there was not a substantial factual basis for the Investigation Committee finding that Physician 1189's use of the tenaculum caused a potentially life threatening vaginal wall and uterine artery laceration, that she failed to recognize a severe life-threatening complication, that she failed to ask for appropriate help, that she recommended sending the patient home with hot packs when she should have understood that further surgery was necessary, or that the patient had a hysterectomy as the result of failures in her clinical practice.

* * *

APPENDIX H

Executive Committee Meeting
January 3, 2007

ITEM	DISCUSSION	PROPOSED ACTION/ RECOM-MENDA-TION/ CONCLU-SION	FOLLOW UP
Update			
Physician #1189	Dr. Lambert reported that the Hearing Committee came back with a split decision recommending that Phys #1189's surgical privileges be terminated but reinstate her non-surgical privileges. Phys #1189 now has the option to appeal this decision. If she elects not to appeal, the Board of Directors will make the final decision. The Board of Directors will give equal weight to the MEC's recommendation to terminate her	For information.	None

	privileges in their entirety and the Hearing Committee's decision noted above.		
Adjournment	was adjourned at 8:52 am.		

Signed:

Bret Lambert, M.D. **Date**
President of the Medical Staff **[REDACTED]**

CONFIDENTIAL RCW 4.24.250
AND RCW 70.41.200

APPENDIX I

* * *

INTERROGATORY NO. 5: With respect to the statement in paragraph 2 of Kornberg's letter of January 5, 2001 that Plaintiff could, at a later date, apply for privileges to perform the laparoscopic procedures for which she was denied privileges in 2001, please explain what requirements, if any, the Plaintiff had to meet before she could apply for the said privileges at a later date.

RESPONSE:

Plaintiff was not denied privileges in 2001. Plaintiff was advised that if she did not revise her privilege application to seek only privileges for relatively simple laparoscopic procedures her request for privileges might be denied. * * * Consistent with the Medical Staff Bylaws, plaintiff was advised at the time that if she wished to apply for privileges to perform laparoscopic procedures beyond those granted through her revised 2001 privilege application, she would have to make a separate application for those additional procedures with evidence of training and experience to support the requested additional privileges and be assigned a preceptor for a provisional period after which the provisional period would be reviewed and a decision would be made as to whether to grant permanent privileges for the additional privileges that were the subject of the subsequent application.

* * *

APPENDIX J

* * *

REQUEST FOR ADMISSION No. 23: Admit that Good Samaritan Hospital did not request the list of Plaintiff's cases from St. Clare's Hospital, Tacoma General Hospital, or St. Joseph's Hospital.

RESPONSE:

Admit.

REQUEST FOR ADMISSION No. 24: Admit that it is common practice for a hospital to obtain from another hospital the case list of a surgeon applying for privileges at the requesting hospital.

RESPONSE:

Admit.

* * *

REQUEST FOR ADMISSION No. 32: Admit that no physician besides Dr. Cecil Snodgrass reviewed the medical records of M536099 before a request for corrective action was made.

RESPONSE:

Admit.

* * *

REQUEST FOR ADMISSION No. 47: Admit that every mechanical step required to operate the machine used to videotape a laparoscopic procedure is performed by the nursing staff while the surgeon is scrubbed and performing the laparoscopic procedure that is being videotaped.

RESPONSE:

Admit.

* * *

REQUEST FOR ADMISSION No. 49: Admit that to be credentialed to perform laparoscopic procedures, physicians are not required to be able to operate videotaping equipment.

RESPONSE:

Admit.

REQUEST FOR ADMISSION No. 50: Admit that nothing prevented the hospital from videotaping Plaintiff's laparoscopic procedures if it wished to do so.

RESPONSE:

Admit.

REQUEST FOR ADMISSION No. 51: Admit that Plaintiff did nothing to prevent the hospital from videotaping her procedures.

RESPONSE:

Admit.

* * *

REQUEST FOR ADMISSION No. 112: Admit that excepting the facsimile information appended at the top of each page, the document attached hereto as Exhibit S is a true and correct copy of the investigating committee's report that was provided to the Medical Executive Committee together with the Exhibits referenced in Exhibit S but not attached to Exhibit S.

RESPONSE:

Admit.

REQUEST FOR ADMISSION No. 113: Admit that Exhibit S was compiled, produced, generated, or otherwise created on a computer in the offices of MillerNash in Seattle.

RESPONSE:

Admit that Exhibit S was compiled through the use of word processing software in the Seattle office of Miller Nash.

* * *

APPENDIX K

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON IN AND FOR THE COUNTY OE PIERCE

VERBATIM TRANSCRIPT OF PROCEEDINGS

Friday, July 25, 2008
Before The Honorable Katherine M. Stolz
Tacoma, Washington

* * *

[p.44] * * *

THE COURT'S RULING

THE COURT: The Court's going to grant the summary judgment motion. I think this case, clearly, is one where there were extensive hearings at Good Samaritan Hospital regarding all of the allegations, that Physician 1189 was ably represented at those hearings. An extraordinary amount of information was provided at those hearings, and it's not my position to second-guess that. Nothing has been shown of any credible

[p.45]

evidence that any of this was fraudulent, maliciously done. The Court will grant the summary judgment motion.

* * *

APPENDIX L

COURT OF APPEALS

* * *

BRIEF OF PLAINTIFF/APPELLANT PAMELA D. COWELL, M.D.

* * *

A hearing was held on Dr. Cowell's summary suspension on July 17-18, and July 24 and 26, 2006, CP 155, before the IC rendered its report, CP 239-57. The hospital called no one present at JW's operations to testify at this hearing. CP 159. The hearing was governed by Art. IV, Sec. 7 of the Bylaws, CP 575-82, and violated several of its provisions. Unbeknownst to Dr. Cowell, two of the HC members appointed by Dr. Lambert, Drs. John Russell and Robert Marsh, were business partners, CP 1486, and Dr. Marsh was appointed in violation of Section 7.d.1.ii, A 36, because he was on the MEC when it considered the five past cases on which the RFCA was based, A 15-17. The hospital failed to disclose Michelle Waterland and Char Taylor as witnesses, CP 1488-89, in violation of Section 7.e.11.ii, A 37, and told Ann Evans she did not have to testify, CP 992 at 12, after which she ****declined even to speak with Dr. Cowell when she attempted to ask her to testify at the hearing. CP 752, ¶ 68. The HC made no findings of facts; it reported only conclusions, which it did not explain. A 44. Neither the report, nor the hearing record was

transmitted to the MEC, A 46, in violation of Section 7.e.15. A 38.

* * *

The IC failed to investigate adequately even the allegations it invented - that Dr. Cowell exceeded the scope of her privileges and failed to cooperate with the peer review process - and did not review many relevant documents or question individuals with relevant information. CP 315-16, 1052 at 32, 1202, 1221, 1062 at 90. The IC did not read Dr. Cowell's letter of August 3, 2000 advising Kornberg that the nurses could not work the video equipment, CP 1052 at 32 , and did not even know that Dr. Cowell had attempted to videotape a procedure, *id.*, 1349 at 46. It did not review the protocol for conducting the focused review or the results of the review. CP 1058 at 60. The IC, therefore, did not know that Theresa Young, the manager of the OR, was responsible for ensuring that laparoscopic procedures were videotaped, or that two videotapes were actually made. *Id.*, CP 1236 at 55-56, 1348 at 43:25-44:2. The IC also did not review the operative report of the case in which it accused Dr. Cowell of not videotaping the procedure, CP 254, 1062 at 91:19-92:5, 1236 at 56, and which expressly states that the procedure was videotaped, CP 1656.

The IC did nothing to determine whether Dr. Cowell had actually exceeded the scope of her privileges by performing four LAVHs. CP 253. It did not review Dr. Eun's reappointment review indicating that Dr. Cowell practiced within the scope of her privileges, A 61, or the minutes of the Surgery Committee meeting indicating that Drs. Eun and Kornberg were present when the first of the four

LAVHs was discussed, CP 1236 at 56. The IC did not speak with Dr. Michaelson to determine the scope of his involvement in the LAVHs, CP 1062 at 90, it did not read the operative reports of the four LAVHs, CP 1242-43 at 80, 82, it did not speak with the operating room to determine if they knew that Dr. Cowell had performed these procedures, CP 1356, ¶ 2, 1362, ¶ 3, and it did not speak with Dr. Eun to determine if he was aware that Dr. Cowell had performed this procedure, *id.* They did nothing to determine whether the laparoscopic component of the LAVHs Dr. Cowell performed was more complicated than the laparoscopic procedures for which she had privileges, CP 1342 at 16, and did not ask Dr. Cowell how she performed LAVHs. Failure to gather potentially important data raises jury questions about the reasonableness of the effort to obtain the facts of the matter.

(b) Defendants's actions did not satisfy 42 U.S.C. § 11112(a)(3).

Dr. Cowell has created a fact question as to whether revocation of her privileges met the standards of 42 U.S.C.§ 11112(a)(3) by proving that material information was withheld from both the MEC and the Board. A 44, 46, 52 at 12-13, 53-56 at 6:18-7:7, 10:15-11:6, 13:18-14:6, 19:21-20:1.

* * *

By concealing material information from the decision making bodies, Defendants denied Dr. Cowell an opportunity to be heard by those who mattered - the MEC and the Board - and violated the due process requirement of § 11112(a)(3). The hospital's hearing

process was also fundamentally unfair because the Board was *required* to give the same weight to the MEC's recommendation as to the HC's recommendation, notwithstanding that the MEC's recommendation was based on factually false information in the IC's report, and was not subject to appeal, CP 1567.

(c) Revocation of privileges violated 42 U.S.C. § 11112(a)(4).

* * *

(i) Dr. Cowell did not exceed the scope of her privileges.

It is undisputed that Dr. Cowell was granted privileges to perform LAVHs in March, 2005, CP 1172, ¶ 13, that prior to that she had privileges to perform vaginal and abdominal hysterectomies but not LAVHs, CP 1170-72, and that she performed *four* LAVHs prior to March, 2005, CP 253, ¶ 4, 478-79, ¶10, 14-16. Therefore, the conclusion in the HC's report, based on these facts, CP 253, that "on multiple occasions [Dr. Cowell] performed surgical procedures exceeding the quite limited scope of surgical privileges that she had been granted, including but not limited to laparoscopic vaginal hysterectomies when she did not have privileges to perform that procedure", had no factual basis in the record. CP 195, ¶ 4.

First, Dr. Cowell's surgical privileges were not "quite limited": she had privileges to perform all major gynecological procedures. CP 489-94, 1170-72; *accord* 1550 at 17, 1557 at 12. Only her *laparoscopic* procedures were limited because she had not been

preceptored for all procedures, unidentified individuals raised unidentified concerns about Dr. Cowell's familiarity with laparoscopic procedures and equipment, and GSH declined to consider procedures Dr. Cowell had performed at other hospitals. CP 320, ¶ 5, 311, 755, ¶ 76, 1098, ¶ 23. Second, Dr. Cowell did not exceed the scope of her privileges on "multiple occasions". She was accused of exceeding them in four LAVHs and an additional case, CP 253, 254, ¶ 2, but O'Brien, who was monitoring Dr. Cowell's cases, concluded that she did not exceed them in this additional case, CP 1156-57.

It does not follow from the fact that Dr. Cowell did not have privileges to perform LAVHs that she exceeded her privileges when she performed the four LAVHs, because a physician who has not been granted privileges to perform a procedure within his or her specialty is authorized to perform the procedure *with someone who does have privileges* to perform the procedure. CP 755, ¶ 78. Members of the IC and HC knew and have acknowledged this. A 68 at 49, 69 at 31-32. Entirely consistent is Dr. Eun's determination that Dr. Cowell had practiced within the scope of her privileges, A 61, notwithstanding that she had performed an LAVH with Dr. Michaelson, which Dr. Eun was aware of because he was present when the case was reviewed by the Surgery Committee, A 62-63, *accord* A 65, ¶ 5. Nor is there any provision in GSH's Bylaws or Rules and Regulations to the contrary, CP 557-612.

It is undisputed that Dr. Cowell performed each LAVH at issue with Dr. Michaelson, A 64, that Dr. Michaelson had privileges to perform LAVH, *id.*, that the IC knew this, CP 1242 at 80-81, and that Dr.

Cowell informed the HC of this fact, CP 1685 at 25. Two experts have stated that Dr. Cowell did not exceed the scope of her privileges by performing these LAVHs with Dr. Michaelson. A 65, ¶ 3, 66, ¶ 1. In addition, the operating room has a list of the surgical privileges each surgeon has been granted, A 65, ¶ 4, and it did not inform Dr. Cowell that she could not perform these procedures with Dr. Michaelson. CP 755, ¶ 77. Nor did anyone claim or inform Dr. Cowell that she had exceeded her privileges after the first LAVH was reviewed by the Surgery Committee. *Id.* This concatenation of facts provides more than sufficient evidence from which a jury could reasonably conclude that Dr. Cowell did not exceed the scope of her privileges by performing these four LAVHs with Dr. Michaelson. And there are additional facts which further prove that even if Dr. Cowell did exceed the scope of her privileges, she did not place any patient at risk by doing so.

First, Dr. Cowell did not knowingly exceed the scope of her privileges, CP 1685 at 25, and was open about doing these procedures. CP 755, ¶ 77. For example, she suggested to Dr. King and Janet Barrett that if there was concern about her familiarity with laparoscopic procedures someone from outside GSH should be asked to observe her more difficult procedures such as LAVHs, CP 338, ¶ 3. Second, the laparoscopic component of the LAVHs Dr. Cowell performed is technically no more advanced or difficult than the laparoscopic procedures for which she did have privileges. CP 755, ¶ 77, 1039-40, 1685 at 23. There was no finding either by the IC or the HC that the laparoscopic component of the LAVHs, as Dr. Cowell performed them, was significantly more advanced than the laparoscopic procedures for which

Dr. Cowell did have privileges, CP 253, 1552 at 22, 1557-58 at 13-14 , and the representation in the ARC's report to the contrary, CP216, § 2, was simply made up by Miller Nash, CP 1578. Third, none of the four LAVHs had any complications, CP 1616-26, and when she did apply for privileges to perform LAVHs in 2005 Dr. Cowell was granted them. CP 1172, ¶ 13. On these facts, a jury could conclude that it would be unreasonable to believe that revoking Dr. Cowell's privileges because she ostensibly exceeded the scope of her privileges by doing LAVHs would protect patients.

(ii) Dr. Cowell cooperated with the peer review process.

* * *

No one ever alleged that Dr. Cowell failed to cooperate with the peer review process before the IC invented this allegation, and the HC credited it. CP 1304 at 39. No one testified at the hearing that she was combative or uncooperative, CP 1559 at 18, and none of the minutes or other documents in Dr. Cowell's files record such a finding or allegation, CP 1552, at 23. All three Directors of Quality Management - Janet Barrett, Maureen Guzman, and Dr. Ronald Morris - stated that Dr. Cowell cooperated fully with the peer review process. CP 1087-88 at 89:20-90:3, 1481, 1666, ¶ 3. In his letter of September 28, 2005, Dr. Morris stated, "Our discussions in committee have been fruitful in resolving most of these issues with you directly", CP 101, ¶ 3. Maureen Guzman testified that no one had ever claimed that Dr. Cowell was "combative". CP 1088 at 90.

Dr. Cowell was asked to videotape her procedures once, not three times, CP 311, attempted to videotape one of her cases, but the nurses could not operative the equipment, CP 314. Dr. Cowell herself suggested videotaping or having someone observe her laparoscopic procedures during the focused review. CP 338. Theresa Young was placed in charge of videotaping her laparoscopic procedures, CP 345, and two videotapes were made, A 14. On the third occasion videotaping was raised, the hospital asked Dr. Cowell to consent, and she did consent, to the videotaping of her laparoscopic procedures, CP 1613, and a case was videotaped. CP 1656.

Videotaping is done by the nurses, not the physician, who is scrubbed. CP 1102, ¶ 47. Surgeons are not even required to know how to videotape procedures to be credentialed for laparoscopic surgery. *Id.* at 48. The hospital had all the wherewithal to videotape Dr. Cowell's laparoscopic procedures, *id.* at 45-46, and neither Dr. Cowell nor anything else prevented the hospital from videotaping her laparoscopic procedures, CP 1103, ¶ 50-51.

Videotaping is not a part of normal peer review, A 66, ¶ 2, and no other Ob-Gyn at GSH besides Dr. Cowell was asked to videotape their procedures, 1094, ¶ 34. On these facts, a jury could conclude that it would be unreasonable to believe that Dr. Cowell failed to cooperate with the peer review process or that revoking her privileges on that ground would protect patients.

* * *

APPENDIX M

COURT OF APPEALS

* * *

REPLY BRIEF OF APPELLANT, PAMELA COWELL, M.D.

* * *

* * * Professor Scott explained this as follows:

"The judge's function to evaluate the evidence for its sufficiency must be carefully distinguished from the jury's function to weigh the evidence for its persuasiveness ... summary judgment should be handled similarly with or without HCQIA. At the summary judgment stage ... ***independently of the defendants' denials and explanations,*** the court should evaluate whether ***the plaintiff's evidence is sufficient*** for a rational factfinder to find in her favor.

Finally, it should be stressed that both HCQIA and the trilogy [of U.S. Supreme Court cases] have only allocated burdens of proof; neither authorizes judicial deference to the actions of peer reviewers .... **the presumption does not serve to increase the weight of plaintiff's burden of proof."**

See Scott, *supra* note 2 at 402-03 (emphasis added).
* * *

* * *

A Review of the sufficiency of rebuttal evidence is not deferential.

Defendants's misconceptions about "extraordinary deference" is based on the Eleventh Circuit's widely quoted *dictum* that HCQIA does not disturb "the preexisting reluctance of courts to substitute their judgment *on the merits* for that of health care professionals". *See* ***Bryan***, 33 F.3d at 1337 (citation omitted); RBr., 25. However, Defendants have misinterpreted *Bryan's dictum*, which was directed at plaintiff's claim that the incidents that caused his termination "did not justify the severe sanction he received". ***Bryan***, 33 F.3d at 1337. What *Bryan* meant by deference was that once it is determined that the hospital's action(s) met HCQIA's standards, the court's inquiry is at an end, and the court may not substitute its judgment for that of peer reviewers **on the merits**, and decide whether the disciplinary action was appropriate or too harsh.[16]

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[16] *Accord* ***N. Colo. Med Ctr. v. Nicholas***, 27 P.3d 828, 840 (Colo. 2001) (stating, "[w]here the requirements of section 11112(a) are fulfilled, we need not extend our inquiry further"); ***Meyer***, 22 P.3d 1142, 1151 (Nev. 2001) ("issue is not whether ... judge or jury believes ... penalty was too harsh"). However, courts have uniformly held that to be reasonable under § 11112(a)(4) the hospital's action(s) must be tailored to the areas of concern. *See e.g.* ***Mathews***, 87 F.3d at 636 (only privileges to perform spine surgery restricted); **Manzetti**, 776 A.2d at 942 (suspension limited to cardiac surgery); ***Poliner***, 537 F.3d at 384 (only cardiac

* * *

1. A jury could reasonably conclude that Dr. Cowell did not exceed the scope of her privileges or place any patients at risk.

The record is devoid of any evidence that anyone thought Dr. Cowell had exceeded the scope of her privileges before the IC contrived this allegation. The HC stated in its report that there was "substantial evidence that [Dr. Cowell] exceeded ... the limited scope of her surgical privileges" on " multiple occasions over a period of years", not only in "non-privileged" LAVHs but in other unspecified cases. **CP 192**. These statements are untrue, there is no basis for them in the record, and this Court does not have to accept conclusions that are factually baseless. The hospital presented the list of privileges Dr. Cowell had been granted to the HC, and these indicated that Dr. Cowell was granted privileges to perform all major non-laparoscopic gynecological procedures, **CP 489-90**, and limitations were placed only on her *laparoscopic* privileges.

* * *

On January 5, 2001, Dr. Kornberg informed Dr. Cowell that she would have to withdraw her application for some laparoscopic procedures but could apply for privileges to perform them at a later date. **CP 318**. The letter did not explain what would qualify Dr. Cowell to apply for privileges she was barred from

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catheterization temporarily restricted, other privileges "untouched").

applying for in January, 2001. *Id.* Dr. Cowell assumed she would have to demonstrate additional experience with the procedures. The hospital confirmed that this was correct. **CP 1210-11**, No. 5 (evidence of training and experience required to support additional privileges requested). Dr. Cowell asked Dr. Michaelson to work with her on LAVHs in which the laparoscopic component was more than *diagnostic* because he was a very experienced laparoscopic surgeon. **CP 755**, ¶ 76.

The IC stated in its report that it *appeared* that Dr. Cowell had exceeded the scope of her privileges by performing four LAVHs. **CP 253, 255**, ¶ 4. Even the IC did not claim that Dr. Cowell had exceeded her privileges "on multiple occasions" or in other cases besides four LAVHS.[22] The sole basis for the IC's claim was that Dr. Cowell had not yet been granted privileges to perform LAVHs. However, Dr. Cowell performed each of the four LAVHs with Dr. Michaelson, who did have privileges to perform LAVHs. **CP 1615**. This fact is omitted from the reports of the IC, HC, and ARC, **CP 239-57, 184-97, 204-17**. The question is whether Dr. Cowell exceeded the scope of her privileges by performing these LAVHs *with Dr. Michaelson*. The following evidence indicates that she did not:

Drs. Eun and Kornberg both knew Dr. Cowell had performed the first of these LAVHs because they attended the Surgery Committee meeting at which the case was presented. **CP 1202-03**. Neither told Dr.

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[22] Dr. Rose testified that the HC did *not* in fact find that Dr. Cowell had exceeded the scope of her privileges in cases other than the ones the IC identified. **CP 1557**, 12.3-13.

Cowell she had exceeded the scope of her privileges. In fact, Dr. Eun determined that Dr. Cowell had practiced within the scope of her privileges even though she had performed this LAVH with Dr. Michaelson. **CP 1221**. The operating room had a list of Dr. Cowell's privileges, **CP 1158, 1628**, yet did not tell her she could not perform LAVHs with Dr. Michaelson.

Dr. Smith, a member of the IC, and Dr. Rose, a member of the second HC, both acknowledged that a physician who did not have privileges to perform a procedure could perform it with them if they had privileges to perform the procedure, **CP 1349**, 49: 13-23; **1562**, 32:18-33:5. Their statements are corroborated by Maureen Guzman, former Director of Quality Management at GSH, **CP 1628**, who testified that Dr. Mott, Chief Medical Officer, has also performed an operation on a patient's knee with another orthopedic surgeon long after he had relinquished his surgical privileges. *Id.*, ¶ 5. Dr. Joseph Sanfilippo, an Ob-Gyn also testified that Dr. Cowell did not exceed the scope of her privileges by performing the four LAVHs with Dr. Michaelson. **CP 1122, ¶ 2.**[23]

Defendants contend that whether Dr. Michaelson was present is irrelevant because Dr. Cowell was listed as the attending. Rbr., 8. However, the designation "attending" did not define Dr. Michaelson's functional role. Attendings have other responsibilities besides the technical aspects of an operation, and Dr. Michaelson declined to bill, and be listed, as the attending when

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[23] * * *

Dr. Cowell offered this precisely because he had not assumed these other responsibilities. **CP 1615**, ¶ 2, 4.

* * *

Finally, Defendants argue that Dr. Cowell's evidence, showing that the record contained no evidence that the LAVHs, as Dr. Cowell performed them, was a technically more advanced laparoscopic procedure than those for which she did have privileges, cannot defeat their immunity because at most it was a "wrong conclusion". Rbr., 41. But this was not an erroneous conclusion the HC drew; the HC did not even consider this question. **CP 1552**, 22; **1557-58**, 13-14. This was a fresh fabrication Defendants made in the ARC's report. **CP 216**, ¶ 3, ABr., 19.

2. A jury could reasonably conclude that Dr. Cowell cooperated with the peer review process.

The record is devoid of any evidence that anyone believed that Dr. Cowell failed to cooperate with peer review before the IC contrived this allegation, and even the IC did not claim she was "combative". **CP 239-57**. Dr. Cowell was investigated almost continuously for five years, and no opportunity lost to place negative comments in her credentialing file. It is, therefore, all the more significant that her file contains not a single allegation or finding that Dr. Cowell was ever "combative" or failed to cooperate with the peer review process, and no witness testified at the hearing that she was. **CP 1559**, 18:8-18. On the contrary, all three Directors of Quality Management involved in peer review of Dr. Cowell stated that she was cooperative. **CP 1087-88**, 89:20-90:3, **1481**, **1666**, ¶ 3.

* * *

The HC asserted that "*Dr. Cowell engaged in a pattern of disregarding commitments she had made to have procedures videotaped*" even though it found that "*the evidence on this point is somewhat confused*". **CP 192**. The record, however, is clear, and devoid of any evidence that Dr. Cowell *disregarded* commitments to videotape procedures. On the contrary, the record documents exactly the opposite.

Dr. Cowell was *asked* to videotape her procedures once, not three times, **CP 311**, and she did not "disregard" the request. Dr. Cowell attempted to videotape a procedure but the nurses could not operate the machine, and Dr. Cowell informed Dr. Kornberg of this fact. **CP 315**. Defendants accuse Dr. Cowell of "blaming the nurses", RBr., 42, but present no evidence that Dr. Cowell's statements were untrue.

Videotaping was raised again prior to the focused review, but Dr. Cowell was not *asked* to videotape her procedures but

> "voluntarily offered to videotape her procedures or have an observer in the operating room during at least 2 of her more complex surgical procedures (specifically the **laparoscopic hysterectomies**)".

CP 338, ¶ 3. Theresa Young (manager of OR) was unequivocally made responsible for assuring that "all procedures are videotaped". **CP 345**. And the third time videotaping was raised, Dr. Lambert merely asked Dr. Cowell *to agree* to the videotaping and

audiotaping of her laparoscopic procedures, not to videotape them herself, and she did agree. **CP 1613.**

It is undisputed that Dr. Cowell did not do, or fail to do, anything that impeded or prevented the hospital from videotaping her procedures if it wanted to. **CP 1103**, ¶ 50, 51. Dr. Cowell never told the IC that there was "no need to videotape" because she did not have any problems and was doing well, RBr., 36. *See* **CP 859-88**. Nor did she argue that it was not her responsibility to video tape "because 'videotaping is not a part of normal peer review'", RBr., 42. **CP 859-88**. Rather, this fact, the fact that no other gynecologist was asked to videotape procedures, **CP 1099-1101**, ¶ 32-42, and that the videotapes made were not reviewed, all indicate that no reasonable person could conclude that by not having all her laparoscopic procedures videotaped Dr. Cowell placed patients at risk or interfered in any way with the delivery of quality care or its evaluation.

* * *

APPENDIX N

COURT OF APPEALS
DIVISION I
SEATTLE, WASHINGTON

* * *

VERBATIM TRANSCRIPT OF RECORDED PROCEEDINGS BEFORE JUDGES MARY KAY BECKER, LINDA LAU, AND & J. ROBERT LEACH
Wednesday, September 9, 2009

* * *

[p.4] * * *

PANEL JUDGE LEACH: Didn't the board that made the ultimate decision have before it all of the information about those elements or those factors?

MR. KADAR: Of course not, Your Honor. The board didn't know why the investigation was commenced. It didn't know why the suspension was imposed. It didn't know that the termination was done for a different reason. It didn't know material facts about the justification for the termination. It didn't know that Dr. Eun had determined that Dr. Cowell practiced within her priv- -- the scope of her privileges. It didn't know that it's not true that --

PANEL JUDGE LEACH: Isn't all of that information contained in the paper record that was transmitted to the board?

MR. KADAR: That was -- no. No, Your Honor. There was no paper record transmitted the board, number one. The bylaws required that the paper record be transmitted to the medical executive committee, which was not done. The only thing transmitted to the

[p.5]

board * * * was an appellate review committee report. It was written by the lawyers. The report was one --

PANEL JUDGE LEACH: Didn't the board have available to it all of the information that was available to the appellate review committee as well?

MR. KADAR: Certainly not, Your Honor.

* * *

[p.7] * * *

PANEL JUDGE BECKER: Did she know that there was this other information from these previous things that you -- you are now talking about? Did she know that they weren't considering that?

MR. KADAR: Your Honor, we don't know what -- we -- we didn't have the appellate review committee report. That was the end of the case. In other words, we didn't know that the appellate review committee report was going to be what it was until it was

delivered to the board. And the board relied solely on the appellate review committee report.

PANEL JUDGE LEACH: You had an opportunity,

[p.8]

your client did, to appear before the board; is that correct?

MR. KADAR: No. Absolutely not. Absolutely not, Your Honor. I don't know where Your Honor gets that from. I mean --

PANEL JUDGE BECKER: Did you have an opportunity --

MR. KADAR: -- the defendants haven't even -- it's not in the bylaws. The defendants haven't even said that. I don't know where Your Honor gets that from. I mean...

PANEL JUDGE BECKER: Did you read -- have an opportunity to read the appellate report and then comment on it to the board in any way?

MR. KADAR: No. Absolutely not. * * *

[p.9] * * *

MR. KADAR: Well, I mean, I'm stunned that the panel has raised what question was before the board. I mean, there's no -- there's no doubt that the appellate review committee report does not contain material facts. There's no doubt that the peer reviewers at each

stage of the peer review ignored material information. I mean, there's no question about that. It's documented in our briefs. And the idea that -- that we somehow had a chance to appeal this to the board and appear before the board or comment on the appellate review committee report after it was rendered, I'm hearing this for the first time. There's absolutely nothing to that in the record. There's no provision for that in the bylaws.

* * *

APPENDIX O

Summary of Activities Phys. #1189
9/1998 – 4/2006
[Excerpt]

Date	Activity
3/5/01	Board letter to Phys #1189 reappointing her for two years. (She is no longer under provisional status as she is only privileged to do simple laparoscopic procedures mentioned above.) **Next reappointment is February, 2003**
5/1/01	Phys. #1189 moves back to Puyallup
11/3/01	File note made by Jan Barrett regarding verification of Phys #1189's affiliation and standing with Multicare and Franciscans.
1/29/02	Memo from OB Chair, Dr. Eun, to Phys #1189 requesting that she review a record referred for quality review (M079810 Suarez) Note: This is not a laparoscopic case. . . . it was OB.
3/30/02	Response received from Phys #1189
4/1/02	Physician reviewer dictated summary of his review of Case #M079810 – results in an opportunity for improvement in clinical care/management.

5/13/02	Case #M458697 reviewed by OB Committee
6/4/02	Dr. King met with Phys #1189 regarding concerns arising in the OR. Phys #1189 voluntarily offers to videotape or have an observer during at least two of her more complex surgical procedures, specifically laparoscopic hysterectomies (Note: She did not have privileges to do this procedure). **The offer to invite an observer into the OR was welcomed by Dr. King.**
6/17/02	Case M372702 discussed. Surgery Committee concurred with course of action. **Hospital to arrange to have an OB/GYN from outside this area come and preceptor three procedures to evaluate surgical technique, use of equipment, and judgment.** Surgery Committee also felt that Executive Committee should be aware of action.
8/21/02	Meeting involving Drs. King, Morris, and Eun on how to proceed with review.
8/23/02	Letter from Dr. Morris, President of the Medical Staff, to Phys #1189 stating MEC has recommended a focused review for up to six months to start 9/1/02 and conclude 12/31/02. **Parameters of review include videotaping laparoscopic procedures, interview with staff, chart reviews and an interview with Physician Assistant**

	Program personnel. Information to be compiled and reviewed by MEC T 2/3/03 meeting with recommendation regarding reappointment. Note: An observer outside the organization could not be secured but Phys #1189 was **encouraged** to have one of her colleagues in the OR during more complex surgical procedures.
2/12/03	Letter from Dr. Morris, President of the Medical Staff, informing Phys #1189 that she is being granted temporary privileges for 60 days to allow time to review data from the focused review.
3/3/03	Results of focused review discussed at MEC – there were no major infractions. Erratic behavior seems to surface when Phys #1189 is in stressful situations. MEC recommended counseling but it was not a condition of her reappointment.
4/9/03	Letter from Board reappointing Phys #1189 for two years. **Next reappointment is April, 2005**
4/18/03	Memo from Jan Barrett to Dr. Eun regarding an informal meeting with Phys. #1189
5/2/03	Summary of meeting with Phys #1189 – she refuses the offer for counseling

8/7/03	Review of Case #M275331 results in an opportunity for improvement in clinical care/management
9/13/04	Five cases of Phys #1189 reviewed by Physician Reviewer. Four cases

CONFIDENTIAL RCW 4.24.250
AND RCW 70.41.200

APPENDIX P

REAPPOINTMENT REVIEW

[See foldout page]

GOOD SAMARITAN HOSPITAL

Completed by QA Office: March 27, 2003
Physician Being Reappointed: Pamela Cowell, MD
Staff Type: Active

Physician Reviewer: Paul Loo, MD
Service: Obstetrics/Gynecology
Specialty: Obstetrics/Gynecology

AREA FOR REVIEW Reappointment Timeframe: 9/1/00 - 8/31/02	# Cases	REAPPOINTMENT REVIEW ✓ Check One:	Meets Expectations	Needs Improvement	Performance Not Met	IF EXPECTATIONS ARE NOT MET, PLEASE COMMENT
SERVICE CO PEER REVIEW • Standard Met • Standard Not Met	5 1	Comment required on all areas where there is an opportunity for improvement or clinical care/staff is not appropriate		/		
CASELOAD • Attending Physician • Associate • Consultant • Surgeon • Assistant Surgeon • Anesthesiologist	202 2 1 170 6 1	Caseload appropriate for medical staff status (active/courtesy) and specialty • Active = Consults and admits consistent with specialty and assumes all functions and responsibilities of membership on the Active Medical Staff • Courtesy = Average no less than one and no more than 24 pts. during a 2 year period	/			
PRIVILEGING • Refer to attached delineation of privilege form • Refer to attached Procedure Reports		Practicing within scope of privileges (procedures appropriate as per privileges requested)	/			
DOCUMENTATION • History and Physical Standard Met/Dictated Timely Standard Not Met/Not Dictated Timely • Operative Report Standard Met/Dictated Timely Standard Not Met/Not Dictated Timely	167 11 181 4	Dictation of history and physicals is timely (meets standard) Dictation of operative reports is timely (meets standard)		/		H&P completion <90%.
SERVICE QUALITY • Refer to attached "compliments" from patients • # of "compliments" • Complaints included in Service Q.I. Peer Review (above)	0 --		/			
QUALITY and PERFORMANCE IMPROVEMENT (QPI) SUMMARY • Refer to Summary		Active Staff: Physician is participating in QPI activities	/			

Comments:

Check one:

_____ Recommend Highly without Reservation
_____ Recommend as Qualified and Competent
_____ Recommend with Reservation
_____ Do not Recommend

Signed: Paul Loo, MD

Today's Date: 5/21/03

10/25/01

CONFIDENTIAL RCW 4.24.250 AND RCW 70.41.200

APPENDIX Q

* * *

I, Pamela Cowell, M.D., hereby voluntarily agree not to exercise my laparoscopic surgical privileges, except laparoscopic tubal ligation and diagnostic exploratory laparoscopy, without a preceptor in attendance until I have successfully completed ten procedures. In addition, I agree to have any laparoscopic procedures I perform videotaped and audio taped for further review by the Peer Review Committee.

Pamela Cowell, M.D. Date

File No.: 523990-2001
Doc ID: SEADOCS:210490.1

APPENDIX R

DATE OF PROCEDURE: 01/21/2006
SURGEON: Pamela D. Cowell, M.D.
ANESTHESIA: General.

* * *

* * * The operation was terminated. Instruments were removed. There was a complete video tape obtained of the entire intraabdominal aspect of the surgery.

* * *	[logo] **Good Samaritan** **Procedure Report** ***Chart Copy***

APPENDIX S

[logo]
Good Samaritan
SURGERY CENTER
A part of MultiCare Health System

Pre-printed Post-Op Orders

Children under 40 kg

- ☐ Fentanyl 0.5-1mcg/kg IV, may repeat in 10 minutes if no pain relief up to total 100mcg prn pain
- ☐ Capital and codeine suspension 120/12mg PO 1-2 tsps prn pain
- ☐ Tylenol elixir 160mg/tsp PO 0.5-2tsps prn pain
- ☐ Tylenol suppository 150-300mg PR prn pain
- ☐ Tylenol with codeine suppository 150mg/15mg or 300mg/30 mg PR prn pain
- ☐ Reglan 0.1-0.2 mg/ kg IV up to 8mg prn nausea
- ☐ Zofran 2-4mg IV prn nausea
- ☐ Anzemet 0.35mg/kg IV prn nausea
- ☐ Other:

Adults over 40 kg

- ☐ Dilaudid 0.5mg IV up to a total of 2mg prn pain
- ☐ Fentanyl 25-50mcg IV up to a total of 200mcg prn pain
- ☐ Toradol 30mg IV prn pain X 1
- ☐ Versed 1-2mg IV for agitation if SaO2 is greater than 92%
- ☐ Demerol 50-75mg with Vistaril 50mg IM prn pain
- ☐ Demerol 12.5mg IV for shakes/shivers, may repeat X2
- ☐ Percocet/Roxicet 5mg or Vicodin 5 mg 1 - 2 tabs PO prn pain
- ☐ B&O suppository 16.2mg/30mg PR prn bladder spasms
- ☐ Anzemet 12mg IV prn nausea
- ☐ Phenergen 12.5-25mg IV prn nausea
- ☐ Reglan 5-10mg IV prn nausea
- ☐ Zofran 4 mg IV prn nausea
- ☐ Vistaril 25mg - 50mg PO prn nausea
- ☐ Compazine 25mg suppository PR prn nausea
- ☐ Darvocet N-100mg 1 tab PO prn pain X 1
- ☐ Ibuprofen 200mg up to a total of 800 mg PPO prn pain

- ☐ May Use Generic Medications

Small Volume Nebulizers prn respiratory distress

- ☐ Racemic Epinephrine
  0.5mL in 2mL NS
- ☐ Ipratropium Bromide
  0.02% 0.5mg/2.5mL
- ☐ Albuterol 2.5MG/0.5mL

Other:

- ☐ Straight Urethral Catheter
- ☐ Blood Glucose
- ☐ Other:

Anesthesia Provider signature: _____

Pt. Name:_____

Date:_____

Revised: 8/07

GSSC-000017

APPENDIX T

GOOD SAMARITAN HOSPITAL
APPEAL OF PHYSICIAN 1189

APPELLATE REVIEW COMMITTEE
DECISION AND RECOMMENDATION

INTRODUCTION

This is the decision and recommendation of the Appellate Review Committee, which was appointed by the Board of Directors. The Appellate Review Committee is comprised of three Directors of Good Samaritan Hospital and is charged by the Board of Directors to review and make recommendations as to whether the adverse recommendation or decision against Physician 1189 made by the Hearing Committee and the Medical Executive Committee was justified and was not arbitrary and capricious.

In this decision we will review the procedural background, the role of the Appellate review Committee, Medical Staff Bylaws compliance, the Hearing Committee's conclusions, the Medical Executive Committee recommendation, and other matters. In addition, we provide the conclusions and recommendations of this Committee. Before we address those issues, we begin by setting the context in which we began this review.

First, we presume Physician 1189 to be a good doctor. She has been on the Medical Staff of Good

Samaritan Hospital since 1998. The credentials of Physician 1189 were examined by the Medical Staff and the Board of Directors upon appointment and thereafter upon reappointment to the Medical Staff.

Second, we view Good Samaritan Hospital as having its own legitimate goals, which goals have the potential for being different from those of the Medical Staff. Such differing goals can arise from the lay majority of the Board that governs the hospital, when compared to the physician governance of the Medical Staff. This potential for diverging goals naturally causes us to be sensitive to any suggestions that the Medical Staff or any of its members have ulterior motives.

Third, we recognize that medical practice involves individual creativity and planning and intervention, and that within the standard of care we should expect some doctors to be relatively conservative and others relatively aggressive in treating patients.

Fourth, we recognize that virtually all physicians who care for hospital patients make mistakes, even good physicians, physicians worthy of membership on the Medical Staff. Mistakes, regardless of whether they are negligent and regardless of whether they affect the treatment outcome, are an inevitable part of medicine. The physician peer review process is a response to this ubiquity of error. In every hospital department the care rendered by physicians is routinely reviewed. As every member of the Good Samaritan Hospital Medical Staff knows, many hundreds of patient records are reviewed annually by peer physicians who are not involved in the patient's

care. Usually the care is found appropriate; sometimes peer physicians identify an opportunity for improvement, and determine what can be done differently next time to improve care. Some physicians, like other professionals, see fault everywhere except in themselves and have no questions and no fears about their abilities. These physicians claim it is the process, not the individuals, that requires close examination and correction. We respect the view of these physicians, however, we believe appropriate peer review addresses the physician, other practitioners, and the process. In this decision and recommendation we address the physician. As to the treating physician, peer review is an opportunity for peer physicians to inculcate in the treating physician the "correct" view of his or her mistake to ensure the physician recognizes the mistake is an opportunity to learn and to understand his or her limitations. To ensure lessons are learned, responsibility is accepted, and the quality of patient care is improved through changed behavior, peer review occasionally requires review of cases following the initial peer review intervention. Sometimes concurrent review, proctoring, and mandatory consultation are needed. Other times, letters of admonition or censure, probation or reduction in clinical privileges is the appropriate remedy, and in some serious cases that include issues of judgment, peer physicians reluctantly and regretfully recommend the removal of the physician's privileges. When such action is required to ensure patient safety, it is through this elaborate process of monitoring in physician peer review that the Medical Staff and the Board of Directors is able to further its stated purpose of ensuring quality patient care at Good Samaritan Hospital.

Fifth, we are mindful that the purposes of the Medical Staff as stated in the Medical Staff Bylaws ("Bylaws") include:

1. *To ensure that all the patients treated in the Hospital receive quality care appropriate to their condition.*
2. *To provide a high level of professional performance and behavior of all practitioners authorized to practice in the Hospital. . . .*

. . .

Article II, Sections 1 and 2.

Sixth, we are aware that in addition to meeting basic standards, such as a license to practice medicine, the Bylaws require that a physician on the Medical Staff "*must also have a demonstrated ability to work with others sufficient to assist the hospital fulfill its responsibility without undue disruption.*

Article IV, Section 1(a).

Seventh, and finally, we want to ensure that it is clear we have taken very seriously our charge to review the quality and safety of patient care provided by Physician 1189 at Good Samaritan Hospital. Federal and state government has recognized the imperative of effective peer review. (*see, e.g.*, 42 U.S.C. 1101 *et seq.*, and RCW 70.41.0200 and 4.24.250). This Committee and the Medical Staff have in aggregate spent hundreds of hours, without compensation or prospect of personal gain, on reviewing the clinical care of Physician 1189. It is in the context of these remarks we present the decision that follows.

I. PROCEDURAL BACKGROUND

On March 3, 2006 the Chair of the Physician Peer Review Committee wrote to the President of the Medical Staff requesting the immediate initiation of corrective action with respect to * * *

* * *

CONFIDENTIAL: THIS DOCUMENT IS PREPARED FOR PURPOSES OF PEER REVIEW AND IT IS PROTECTED BY RCW 70.41.200 AND RCW 4.24.250

APPENDIX U

CONFIDENTIAL PEER REVIEW

GOOD SAMARITAN HOSPITAL
APPEAL OF PHYSICIAN 1189

APPELLATE REVIEW COMMITTEE
DECISION AND RECOMMENDATION

I. PROCEDURAL BACKGROUND

On March 3, 2006 the Chair of the Physician Peer Review Committee wrote to the President of the Medical Staff requesting the immediate initiation of corrective action with respect to Physician 1189. The letter made reference to two medical charts (M526729 and M536099) and stated, as the basis[1] for the request:

> *I am concerned about the continued theme of patient care issues and the lack of insight into these problems and believe physician 1189's current and past clinical practices are detrimental to the health and safety of patients.*

[1] The request for corrective action also mentioned going outside of the peer review process by sending letters to many individuals about cases. However, this basis for the request for corrective action was not pursued by the Investigation Committee nor was any evidence presented about this basis for the request during the course of the hearing.

Physician 1189 was advised of the request for corrective action on March 6, 2006 and the resultant initiation of an investigation into her clinical practices. The two medical charts were identified but Physician 1189 was informed that the investigation of her clinical practices would not be limited to the two charts.

On March 7, 2006, Physician 1189 was advised of the identities of the Investigation Committee. In response, through the attorneys representing her at the time, Physician 1189 requested that an OB/GYN be included on the Investigation Committee. This request was declined.

On April 28, 2006, following a complication occurring in the course of a tubal ligation, Physician 1189's clinical privileges at Good Samaritan were summarily suspended. In response, Physician 1189 requested, and was granted, a hearing on the summary suspension.

On May 3, 2006 the Investigation Committee invited Physician 1189 to meet with them. The letter inviting Physician 1189 to meet contained a list of questions that the Investigation Committee wanted Physician 1189 to be prepared to address at the time of the meeting. Through her lawyer at the time, Physician 1189 requested that the meeting be postponed. The Investigation Committee agreed to postpone the meeting but not to put the investigation on hold.

On June 16 and July 3, 2006 the Investigation Committee met with Physician 1189. The Investigation Committee did not tape record or

otherwise provide for a verbatim recording of the meetings. However, Physician 1189 did tape record both meetings and did have available to her a verbatim transcription of the meetings.

The hearing on the summary suspension of Physician 1189's privileges took place over a series of evenings between July 17 and July 26, 2006. This Hearing Committee issued its decision upholding the summary suspension on August 2, 2006.

The Investigation Committee issued its report and recommendations on July 29, 2006. The Investigation Committee recommended termination of Physician's clinical privileges. On August 6, 2006, the Medical Executive Committee met to consider this recommendation. Physician 1189 was invited to attend a portion of this meeting to provide her comments on the recommendation which she did. At the conclusion of consideration, the Medical Executive Committee voted to adopt the recommendation of the Investigation Committee.

On August 10, 2006, Physician 1189 was notified of the action of the Medical Executive Committee and informed of her procedural rights, including the right to a hearing regarding the recommendation. In response, Physician 1189 requested a hearing.

A hearing committee was appointed and a hearing on the MEC recommendation occurred over a series of evenings and days in November and December 2006. On December 29, 2006, the Hearing Committee issued its report and recommendation. The recommendation of the Hearing Committee was to

terminate Physician 1189's surgical privileges but to reinstate all other privileges that Physician 1189 enjoyed at the time of the summary suspension.

Physician 1189 sought, and was granted, appellate review of the recommendation of the Hearing Committee. Physician 1189 submitted two appellate statements. One statement addressed the MEC recommendation and the other addressed the Hearing Committee recommendation. The MEC submitted a single statement in response and Physician then submitted a final statement in reply to the MEC submittal.

Physician 1189 also requested and was allowed an opportunity to make an oral presentation to the Appellate Review Committee. The oral presentation occurred on March 19, 2007 with Physician 1189's representative and the MEC representative each allowed thirty (30) minutes for their presentation. At the conclusion of these presentations, the Appellate Review Committee began its deliberations.

II. ROLE OF APPELLATE REVIEW COMMITTEE

The Medical Staff Bylaws ("Bylaws") allow appeals to be heard either by the Governing Body or a duly appointed appellate review committee of the Governing Body consisting of no fewer than three (3) members of the Governing Body. The undersigned are the three (3) duly appointed members constituting the Appellate Review Committee. The appointed Appellate Review Committee is charged with making a recommendation to the Governing Body to affirm, modify, or reverse the underlying recommendation or

to refer the entire matter or specific issues back to the Medical Executive Committee for re-hearing.

The Bylaws provide that the role of this Appellate Review Committee is not to provide a second fair hearing to the practitioner. The Bylaws are very clear that a practitioner is entitled to only one fair hearing in connection with any adverse action, as that phrase is defined in the Bylaws.

In formulating its recommendation to the Governing Body, the Appellate Review Committee is to review the recommendation(s) of the Hearing Committee and to determine whether the decision and recommendation was justified and not arbitrary and capricious. To this end, the Appellate Review Committee reviewed the record created before the Hearing Committee during the fair hearing on the Medical Executive Committee's recommendation of termination of all Physician 1189's clinical privileges at Good Samaritan Hospital. This record consisted of the verbatim transcript of the testimony of the witnesses and the opening statements and closing arguments of counsel for the parties. The record also consisted of the exhibits offered and admitted during the course of the fair hearing.

In addition, the Appellate Review Committee reviewed the two appellate statements submitted by Physician 1189, the responding appellate statements submitted by the President of the Medical Staff, and the rebuttal appellant statement submitted by Physician 1189. Finally, on March 19, 2007, the Appellate Review Committee heard oral presentations by counsel for Physician 1189 and by counsel for the Medical Executive Committee. The Appellate Review

Committee believes that it is fully informed with respect to the Hearing Committee decision and recommendation.

In addition to review of the Hearing Committee decision and recommendation, the Bylaws require that the Appellate Review Committee consider and give equal weight to the Medical Executive Committee recommendation. The Appellate Review Committee has followed the requirements of the Bylaws and makes the following findings, conclusions, and recommendations.

III. MEDICAL STAFF BYLAW COMPLIANCE

Physician 1189 has alleged that the Medical Executive Committee and the Investigation Committee violated procedural provisions of the Bylaws in the course of the investigation of the current and past clinical practices of Physician 1189. In particular, Physician 1189 has alleged that the process employed by the Medical Executive Committee and the Investigation Committee was improper and/or in violation of the Bylaws in the following respects:

1. The Medical Executive Committee declined a request to put an OB/GYN physician on the Investigation Committee.

2. The Investigation Committee failed to complete the investigation within 30 days.

3. The Investigation Committee failed to tape record its meetings with Physician 1189 and to provide her a transcription of the recording.

4. The Investigation Committee failed to provide Physician 1189 with the opportunity to rebut or discuss the allegations regarding her past cases.

5. The Investigation Committee exceeded the scope of its investigatory authority by investigating Physician 1189's relations with the peer review process and performance of procedures outside the scope of her clinical privileges.

6. Physician 1189 was not given adequate notice of the issues.

A. Appointment of an OB/GYN to the Investigation Committee.

The Appellate Review Committee finds that Physician 1189 did request that an OB/GYN be appointed to the Investigation Committee from outside of the Hospital medical staff and that the Medical Executive Committee declined the request.

There is no provision in the Bylaws that requires the appointment to an Investigation Committee of a physician practicing the same specialty as the physician under review. In this instance, Physician 1189 had the opportunity to provide the Investigation Committee with multiple OB/GYN expert reports on the cases under consideration.

For these reasons, the Appellate Review Committee concludes that the failure to appoint an OB/GYN to the Investigation Committee did not violate any provision of the Bylaws. Furthermore, it was not unfair to Physician 1189 nor did it prejudice her in any way in light of her opportunity to submit

multiple favorable expert reports to the Investigation Committee for its consideration in reaching its decision and recommendation.

B. Duration of Investigation.

Physician 1189 is correct in stating that the Bylaws provide for an investigation to be completed within 30 days of the appointment of the Investigation Committee. Physician 1189 is also correct that this Investigation Committee exceeded the 30 day period in conducting and completing its investigation.

However, the Appellate Review Committee further finds that Physician 1189 was represented by counsel from the very inception of the investigation and that Physician 1189's counsel communicated with the Medical Executive Committee through its counsel from the outset of the investigation. The Committee further finds that counsel representing Physician 1189 were aware of the Bylaw provisions regarding the duration of an investigation and that, further, neither Physician 1189 nor her counsel every objected to the duration of the investigation until after it was completed.

The Appellate Review Committee further finds that a reasonable and thorough investigation into the current and past clinical practices of Physician 1189 could not have been completed within 30 days of the formation of the Investigation Committee.

Based on the foregoing, the Appellate Review Committee concludes that Physician 1189 acquiesced in the continuation of the investigation beyond the 30 day period mentioned in the Bylaws and that

Physician 1189 was not prejudiced or otherwise treated in an unfair manner by reason of the duration of the investigation.

C. Record of the Investigation Committee Interviews with Physician 1189.

With respect to the record to be created of the Investigation Committee interview with a practitioner, the Bylaws provide:

> *This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interviews shall be made by the Investigation Committee and included with its report to the Executive Committee. A copy of the practitioner's interview and committee findings will be sent to the practitioner.*

Article IV, Section 6(a)(3).

Physician 1189 apparently takes the position that this Bylaw provision requires the creation of a verbatim record of the interview by tape recording or otherwise. Physician 1189 contends that the Investigation Committee violated this Bylaw provision by not creating a verbatim record of the interview.

The Investigation Committee report does contain a record of the interviews in that the report contains recitations of the substance of the interview. The Investigation Committee did not, however, provide for the recording of the interviews by any mechanism

other than the notes and recollections of the Investigation Committee.

While the above-quoted Bylaw provision, read in isolation, may suggest a requirement of a verbatim record of an Investigation Committee interview with a practitioner, reading it in the larger Bylaw context does not support such a conclusion. This provision makes clear that this interview is not to be confused with a hearing and that the procedural rules for hearings do not apply at this interview stage.

With respect to hearing procedures, regarding the creation of a record, the Bylaws provide:

> *An accurate record of the hearing must be kept. The Hearing Committee shall establish the mechanism. In addition, the practitioner shall have the right to a copy of a written record of the proceeding and shall bear the costs of same based upon reasonable charges.*

Article IV, Section 7(e)(2).

Had the Bylaws intended to create a similar requirement for any interview with an Investigation Committee, the same or similar language would have been used. Based on this review of the Bylaw language, we conclude that the Bylaws do not require the creation of a verbatim record of the Investigation Interview.

Furthermore, Physician 1189 was not prejudiced by the failure of the Investigation Committee to provide for a verbatim recording of the interview since

she recorded the interview and had a transcription of the interview prepared for her use.[2]

D. Failure to Provide an Opportunity to Rebut or Discuss Past Cases.

Physician 1189 contends that she was denied the opportunity to discuss, explain or refute the allegations against her based on her past cases, and that this violated the Bylaws. This Bylaw provision applies to the interview with the Investigation Committee and states:

> *Before such interview, the practitioner shall be informed of the specific charges against him and shall be invited to discuss, explain or refute them.*

Article IV, Section 6(a)(3).

The Investigation Committee did not independently review the medical charts relating to the past cases. Rather, as part of its investigation, it reviewed the contemporaneous reviews of the charts performed by various quality assurance/peer review committees and, in the case of five charts, an outside reviewer. In each of the past cases, Physician 1189 was provided a contemporaneous opportunity to discuss, explain, or refute the allegations regarding these past

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[2] We note Dr. Taggart's testimony that the two interview sessions in total took over four hours. Presumably Physician 1189 had a transcription of the entire four plus hours of interviews yet chose to submit excerpts from the transcription that reflected exchanges occupying a very minimal portion of the four plus hours of interviews.

cases and in each of the cases, Physician 1189 availed herself of this opportunity. The record reflects that Physician 1189 met with the committees reviewing these cases during the course of the committee review to provide oral comment and that she provided substantial written comment and response as well.

The Investigation Committee's consideration of these past cases was an effort to establish a context in which to assess the current cases to determine whether the current cases were aberrational or part of a larger pattern of practice. They did not raise new or different issues about these cases that had not been raised and addressed by Physician 1189 when these cases were subject to peer review. Physician 1189 was provided an opportunity to discuss, explain, and refute allegations about these cases at the time they were considered. The Investigation Committee did not violate the Bylaws by not expressly revisiting these past case discussions during its interviews with Physician 1189, and Physician 1189 was not prejudiced by any lack of opportunity to revisit these cases.

E. The Investigation Committee Exceeded the Scope of its Authorized Investigation.

Physician 1189 contends that the Investigation Committee was not authorized to investigate and report on her performance of procedures outside of the scope of her privileges and the extent of her cooperation with the peer review process. Physician 1189 contends that the language of the request for corrective action establishes the limits of any investigation undertaken pursuant to that request.

In our view, the request for corrective action embraced within its scope Physician 1189's compliance with the extent of her privileges and cooperation with peer review.

The request for corrective action encompassed Physician 1189's current and past clinical practices. A fundamental aspect of any physician's clinical practice is the scope of the privileges afforded that physician. Privileges are awarded based on the demonstrated skill and competence of the physician. In this regard, the Bylaws provide:

> *Every practitioner practicing in the Hospital by virtue of the Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body except as provided for in Section 5, subparagraphs "b" and "c".*
>
> . . .
>
> *Clinical practice privileges shall be granted in accordance with prior education and training, prior and current experience, utilization practice patterns, current health status, and demonstrated current competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file.*

Article IV, Sections 5(a)(1) and (2).

A physician who performs procedures outside of the privileges afforded the physician is performing procedures beyond those for which he or she has

satisfactorily demonstrated skill and competence. If a physician consistently exceeds her privileges this becomes an aspect of the physician's clinical care that is properly subject to investigation.

For much the same reason, cooperative and collaborative participation in on-going peer review is an aspect of and factor in clinical care. Here, the Bylaws provide:

> *Recommendations concerning appointment and clinical privileges shall be based upon evidence . . . such member's professional competence and clinical judgment in the treatment of patients as evidenced by the results of Medical Staff quality assurance peer reviews, . . .*
>
> . . .
>
> *Determination of any privileges for appointment, reappointment, provisional review period . . . will include observed clinical performance, documented results of quality review, . . .*

Article IV, Section 4(b) and Section 5(a)(2).

The Investigation Committee did not exceed its charge to investigate Physician 1189's past and current clinical practices by investigating her performance of procedures outside of her privileges or her relations with the peer review process.

F. Physician 1189 did not Receive Adequate Notice of the Charges Against Her.

Related to her contention that she was not provided an opportunity to discuss and refute

allegations regarding her past cases and her contention that the Investigation Committee was not authorized to investigate whether she exceeded her privileges and cooperated with peer review, is Physician 1189's general contention that she was not provided adequate notice of the charges against her. In written materials submitted to the Appellate Review Committee, and particularly in comments at the oral presentation to this Committee, Physician 1189 stressed that she was denied this fundamental aspect of due process. The record does not support her contentions.

The initial March 6, 2006 letter to Physician 1189 regarding the scope of the investigation informed her of concerns that her clinical practice may indicate a pattern of care that is detrimental to the health of patients and the delivery of quality care. It advised her that the Investigation Committee would not limit its investigation to the two charts mentioned in the letter. At this time, Physician 1189 was certainly aware that in the last quarter of 2005, the Peer Review Committee had expressed significant concern over her clinical care in connection with four earlier cases and that, in response to those concerns, she had agreed to voluntarily limit the types of laparoscopic procedures she performed.

On May 3, 2006, the Investigation Committee invited Physician 1189 to meet with them and provided Physician 1189 a list of questions they wished her to be prepared to address. Among the issues Physician 1189 was asked to be prepared to address were: (1) her response to the peer review suggestion that she pursue some form of counseling; (2) the reasons for her belief that this review of her clinical

practices was retaliatory; (3) the scope of her practice in terms of her clinical privileges; (4) the breadth of the laparoscopic procedures she intended to continue to perform, and; (5) specific video tapes of procedures periodically required as a result of previous peer review of her clinical practices. A similar letter was sent to Physician 1189 on June 16, 2006 for the rescheduled May 9, 2006 meeting.

The Investigation Committee met with Physician 1189 for approximately three hours in their initial meeting. This was followed by a second meeting in July, 2006 that lasted an additional hour and one-half.

The Investigation Committee issued its report and recommendations on July 28, 2006. Physician 1189 received a copy of the report and recommendations and certainly was informed by the report of both the past cases that had been considered by the Investigation Committee and the issue of performing procedures beyond her privileges. The hearing on the Medical Executive Committee's affirmation of the Investigation Committee recommendation began on November 6, 2006.

The Hearing Committee expressly addressed Physician 1189's contention that she did not have adequate notice of the charges against her. The Hearing Committee found:

> *Physician 1189 was on notice of the issues discussed in the Investigation Committee Report and had an adequate opportunity to provide a response as to such issues.*

Based on the record we have reviewed, including the specific portions identified above, the finding by the Hearing Committee that Physician 1189 had notice of and an adequate opportunity to respond to the issues discussed in the Investigation Committee Report is justified and not arbitrary and capricious.

IV. THE HEARING COMMITTEE'S CONCLUSION THAT THE RECORD CONTAINED LITTLE OR NO CREDIBLE EVIDENCE OF A CONSPIRACY OR RETALIATION AGAINST PHYSICIAN 1189 IS JUSTIFIED AND NOT ARBITRARY AND CAPRICIOUS.

In her written submittals to this Appellate Review Committee, Physician 1189 refers to the investigation of her past and current clinical practices as a "witch hunt" intended not as good faith peer review but as a search for everything and anything that could be used to discredit her professionally. Physician 1189 accuses the Medical Executive Committee of violating the Bylaws to insure that "the troika hand-picked by Dr. Lambert" would conduct the investigation into her current and past clinical practices.

The oral presentation on behalf of Physician 1189 to the Hearing Committee at the inception and conclusion of the hearing followed a similar theme, i.e., those involved in the peer review process, including the members of the Investigation Committee, were out to get Physician 1189 and did not engage in good faith peer review. The Hearing Committee concluded:

No credible evidence exists of retaliation or conspiracy against Physician 1189.

The Hearing Committee was in a position to judge the credibility of the witnesses and concluded that the witnesses appeared to testify in a straightforward manner to the truth as they viewed it. Based on our review of the record, the appellate statements provided and the oral presentations, we conclude that the Hearing Committee was justified in finding no credible evidence of any conspiracy or effort to retaliate against Physician 1189 by any participant in this peer review activity. This conclusion was not arbitrary and capricious and we affirm this conclusion.

V. THE HEARING COMMITTEE'S FINDING THAT PHYSICIAN 1189 REPEATEDLY PERFORMED PROCEDURES OUTSIDE THE SCOPE OF HER PRIVILEGES AND ITS RECOMMENDATION OF TERMINATION OF SURGICAL PRIVILEGES WAS JUSTIFIED AND NOT ARBITRARY AND CAPRICIOUS.

The evidence in the record is undisputed that on multiple occasions between January 2001 and early 2005, Physician 1189 performed a procedure referred to as a laparoscopic assisted vaginal hysterectomy (LAVH).

The evidence in the record also is undisputed that she neither applied for nor was granted privileges for this procedure until after early 2005. For these reasons, we conclude that the Hearing Committee finding that Physician 1189 performed surgical procedures exceeding the quite limited scope of her

surgical privileges over a period of years was justified and not arbitrary and capricious.

The Hearing Committee further concluded that Physician 1189's performance of surgical procedures beyond the scope of her quite limited surgical privileges reflected either a deliberate defiance of important Hospital regulations or a failure to carefully comply with such regulations and, in either case, was detrimental to the health and safety of patients.

The evidence in the record reflects that in January 2001, at the request of the then chair of the surgery department, Physician 1189 agreed to voluntarily reduce the scope of the privileges for which she would apply to avoid the possibility that she would be denied privileges which would have to be reported to the National Practitioner's Data Bank. Physician 1189 took this request that she voluntarily reduce the scope of the privileges for which she would apply sufficiently seriously to consider changing her status to inactive and focusing her surgical practice at another hospital.

Physician 1189 appears to take the position before this Appellate Review Committee that: (1) she misunderstood the process for obtaining privileges that she had voluntarily given up and/or (2) she was granted these additional privileges upon her reappointment because the form completed in this process in 2003 indicated that she practiced within her privileges.

Physician 1189's contention that she misunderstood the process for reviving the privileges she had voluntarily given up is based on the wording of a 2001

letter from the then chair of the surgery department. In that letter, Dr. Kornberg advises Physician 1189 as follows:

> *Should you wish to do other laparoscopic procedures in the future you can apply for those specific procedures at that time and a preceptor can be assigned to work with you on the first five cases. These privileges would also require a provisional review period followed by a recommendation by the preceptor to advance to full status.*

Physician 1189 states that she interpreted this letter to advise her that she should find a preceptor for any procedures she voluntarily gave up in 2001, have that preceptor work with her, and then apply for the additional privileges. To the contrary, the sequence in the sentence is to first make application for privileges for the specific procedure and then have a preceptor assigned. In addition, this is the only reading of this sentence that comports with the Bylaw requirements for reviving privileges that a physician voluntarily relinquished. The Bylaws provide:

> *To renew or reinstate a privilege that has been voluntarily or involuntarily reduced will require completion of the privilege request and approval process for the specific privilege(s) to be renewed.*

Article IV, Section 5(a)(2).

In addition, with respect to provisional privileges, the Bylaws provide:

> *Provisional staff members shall be assigned to a service where their performance shall be observed by a preceptor assigned by the Medical Staff Committee chair, or Credentials Committee chair, or the President of the Medical Staff or the Executive Committee to determine the eligibility of such provisional members for regular staff membership and for exercising the clinical privileges provisionally granted to them.*

Article IV, Section 4(b).

The language of the 2001 letter, and the wording of the Bylaws, make it very clear that the process for reviving privileges voluntarily relinquished required an application, the assignment of a preceptor and a provisional period. It is undisputed that Physician 1189 did not follow this process.

The evidence in the record is also undisputed that this procedure, LAVH, is considered to be a significantly more advanced laparoscopic procedure than the laparoscopic procedures for which Physician 1189 had privileges. The evidence in the record, including Physician 1189's own writings, establishes that Physician 1189 acknowledged that even the most simple laparoscopic procedure, for which she had privileges, was a major surgery, involving blind entry into the peritoneal cavity with long sharp instruments requiring expert knowledge of anatomy and instrumentation to assure patient safety.

In sum, the evidence in the record establishes that Physician 1189 knew the extent of her surgical privileges, knew and acknowledged her personal responsibility for practicing within the privileges

granted her by the Hospital, and knew and acknowledged that even the simple surgical procedures for which she had privileges were surgical procedures that placed patients at substantial risk unless expertly performed. Yet, despite this knowledge and these acknowledgements, Physician 1189 proceeded on multiple occasions to perform more complicated surgical procedures for which she did not have privileges placing both patients and the Hospital at risk.

Regardless of whether Physician 1189 engaged in this clinical conduct out of indifference to critical Hospital regulations or in defiance of these regulations, the clinical conduct is unacceptable. Aside from on-going peer review, which the Hearing Committee also found to be problematic regarding Physician 1189, the awarding of privileges of a specified scope consistent with the physician's demonstrated competence and training is the mechanism by which the Hospital discharges its fundamental obligation for patient safety. The Hearing Committee's recommendation of termination of surgical privileges based on Physician 1189's repeated performance of surgical procedures for which she did not have privileges was justified and not arbitrary and capricious.

VI. THE HEARING COMMITTEE'S CONCLUSION THAT PHYSICIAN 1189 HAD A COMBATIVE HISTORY WITH PEER REVIEW AND THAT SUCH HISTORY SUPPORTED TERMINATION OF SURGICAL PRIVILEGES WAS

JUSTIFIED AND NOT ARBITRARY AND CAPRICIOUS.

The Hearing Committee found:

> *Physician 1189 has had a combative history with the peer review process. A substantial factual basis exists for finding that Physician 1189 has been unwilling to engage collaboratively in the peer review process.*
>
> *. . .[Physician 1189] has failed to engage fully and cooperatively in the peer review process.*
>
> *Effective peer review in one important method for the Medical Staff to assure patients that physicians are competent to hold the clinical privileges granted to them.*

For the reasons stated below, each of these findings is justified and not arbitrary and capricious.

The Bylaws reflect the relationship between on-going peer review and physician privileges. The Bylaws provide that recommendations concerning privileges are to be based, in part, on "*...clinical judgment in the treatment of patients as evidenced by the results of the Medical Staff quality assurance peer reviews...*". The Bylaws similarly provide that "*...[d]etermination of any privileges . . .will include ...documented results of quality review...*".

State law mandates that every hospital must maintain a quality improvement program that has as one of its elements a quality improvement committee with responsibility for reviewing both prospectively

and retrospectively the medical services provided in the hospital in order to improve the quality of medical care provided to patients.

At the federal level, in the passage of the Health Care Quality Improvement Act of 1986, Congress found that the need to improve the quality of medical care had become a nationwide problem that could be remedied through effective professional peer review.

As a factual matter, the record supports the conclusion of the Hearing Committee that Physician 1189 did not cooperate or work collaboratively with the peer review process and that her approach was combative. In multiple documents prepared by Physician 1189 in response to quality assurance committee reviews of her cases between 2001 and 2005, Physician 1189 not only did not accept any meaningful responsibility for the issues raised in the quality assurance review but took the opportunity to criticize hospital administration, medical staff, and other physicians for what she regarded as their shortcomings, often in instances wholly unrelated to the cases under review.

Based on quality review of her cases, it was recommended to Physician 1189 that she get counseling. She declined to do so. On multiple occasions between 2000 and 2005, Physician 1189 was requested to or required to video tape her laparoscopic procedures. She consistently failed to obtain the required or requested video tapes, citing, as justification for this failure, the inability of nurses to operate the equipment, the failure of a member of the hospital administrative staff to provide for video

taping, or her misunderstanding of what procedures were to be video taped.

A physician who will not work collaboratively with the peer review process but instead maintains a combative attitude to the process impairs the ability of the medical staff and the hospital to improve the quality of medical care provided to patients. The Hearing Committee's consideration of Physician 1189's disregard of, or perhaps distain for, the peer review process as a factor in its recommendation to terminate her surgical privileges was justified and not arbitrary and capricious.

VII. CONSIDERATION OF THE MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION.

In making our recommendation to the Governing Body, the Bylaws require that we give equal weight to the recommendations of the Hearing Committee and the recommendations of the Medical Executive Committee. As discussed above, we have considered the recommendations of the Hearing Committee and now turn to the recommendations of the Medical Executive Committee.

On August 1, 2006, the Medical Executive Committee informed Physician 1189 that it had received the Investigation Committee report, that the report strongly recommended termination of her privileges, and that it would meet and consider this recommendation on August 7, 2006. Physician 1189 was invited to attend this meeting to address the Medical Executive Committee before it took action on

the report. Physician 1189 attended the MEC meeting and responded to the concerns raised in the report.

On August 9, 2006, the MEC notified Physician 1189 that based on its review of the Investigation Committee report and its meeting with her, it unanimously voted to recommend termination of her clinical privileges. Thus, the difference between the two recommendations involves only nonsurgical privileges.

In considering our recommendation, we are cognizant of the fact that the Investigation Committee, as well as earlier quality assurance committees, reached different conclusions from those reached by the Hearing Committee on the question of whether Physician 1189's clinical practice met the standard of care in the specific cases reviewed. We are similarly cognizant of the fact that expert opinion on the same question also varied with experts retained by Physician 1189 stating that her clinical practices met the standard of care and the expert retained by the Medical Executive Committee stating that her practice in the case that precipitated the summary suspension did not meet the standard of care. We are further cognizant of the fact that the Hearing Committee, while finding insufficient evidence to support conclusions that Physician 1189's clinical practices fell below the standard of care, nonetheless recommended the termination of all of her surgical privileges based on the persistent pattern of performing procedures beyond the scope of her privileges and her combative history with the peer review process.

VIII. RECOMMENDATION.

Based on our careful review of the Hearing Committee decision and recommendations, the Investigation Committee report and recommendations, the record created before the Hearing Committee and the written and oral presentations to this Committee, and giving equal weight to the Hearing Committee and Medical Executive Committee recommendations, it is our recommendation that all of Physician 1189's clinical privileges at Good Samaritan Hospital be terminated.

The Hearing Committee made its recommendation based on its justified conclusion that the Physician 1189's combined and persistent conduct of practicing beyond the scope of her privileges and a combative, non-cooperative approach to the peer review process was detrimental to the health and safety of patients. Our paramount concern also must be the health and safety of patients of Good Samaritan Hospital. In our view, the justified conclusions of the Hearing Committee regarding Physician 1189's indifference to or defiance of the limitations of her clinical privileges and her combative attitude toward the peer review process are not procedure specific. If the combination of indifference to or defiance of her limited privileges and non-cooperation with the peer review process make Physician 1189's practice detrimental to patient health and safety, it is her entire practice not any limited aspect of it. Since we conclude, for the reasons stated above, that the Hearing Committee was justified in coming to these conclusions, and giving equal weight to the MEC recommendation, we must recommend termination of

all Physician 1189's clinical privileges at Good Samaritan Hospital.

DATED this _____ day of _____, 2007.

_____

_____

_____

MEC PROPOSED FORM OF DECISION AND RECOMMENDATION
SEADOCS:270450.2

APPENDIX V

STATE OF WASHINGTON
BENTON COUNTY

AFFIDAVIT OF JANET BARRETT, R.N.

[June 13, 2008]

* * *

2. I am a registered nurse, and nationally certified professional in the field of health care quality, in which I have worked for more than twenty years. I was hired as the first Director of Quality Management of Good Samaritan Hospital in September-October, 2001, and resigned for personal reasons in April or May, 2003. As Director of Quality Management, I was responsible for quality management, medical staff services, patient relations, and accreditation. In that capacity, I was involved in the peer review of Dr. Pamela Cowell's cases, and in a focused review of all her cases during the period September 1, 2002 through December 31, 2002.

* * *

I found that Dr. Cowell cooperated fully with the peer review of her case and with our efforts to arrange for the focused review of her cases.

* * *

FURTHER AFFIANT SAYETH NOT.

/s/ Janet M. Barrett
Janet Barrett, R.N.

Signed before me on this

13 day of June, 2008.

[Notary Seal]

/s/ JoAnn F. Thometz

DEPOSITION UPON ORAL EXAMINATION OF KENNETH EDSTROM, M.D.

[November 14, 2007]

* * *

[p.34] * * *

Q. Now, you went back and you made some very poignant statements about QA. Do you think that's how normally QA works, that factual errors are not correct and they go on and on and then new allegations, is that normal?

A. That's not normal.

Q. Not normal, okay.

MR. MONTGOMERY: Just object to the form of the question as far as it misstates the evidence.

Q. (BY MR. KADAR) That's not normal, is it?

[p.35]

A. I don't believe that's how it's normally done in this certain hospital, nor how it should be.

* * *

ANNE EVANS,

[March 26, 2008]

sworn as a witness by the Notary Public, testified as follows:

* * *

[p.12] * * *

Q. Just one second. Generally speaking, how would you describe Dr. Cowell's sort of demeanor? Is she a calm kind of person, a hyper kind of person, or

[p.13]

if you can, do you have an opinion? What is she like?

A. Calm.

Q. Is she calm?

A. Yes. Very nice lady.

* * *

Q. So you enjoyed working with her?

A. Yes.

* * *

TRANSCRIPT OF THE CONFIDENTIAL HEARING OF PHYSICIAN 1189

[December 11, 2006]

* * *

[p.97]

MICKIE LYNN FAGERSON,

having been called as a witness by Physician 1189, was duly sworn and testified as follows:

* * *

[p.98]

Q. How long have you worked here?

A. Total of almost 20 years * * *

* * *

Q. * * * Have you ever received any awards while you were working at Good Sam?

A. I have.

Q. What did you receive?

A. Well, I received the Samaritan award. I received Nurse Excellent award from the emergency room in the '90s. And this last year, I received an award that was given to four nurses in the western Washington area, and I was one of the four.

* * *

[p.99] * * *

Q. * * * have you ever seen her in what you would describe as stressful situations?

A. Well, I've seen her in stressful situations, yes.

[p.100]

Q. And have you observed other OB-GYNs under stressful situations?

A. Yes, of course.

Q. Now, from your observations of Dr. Cowell, have you formed a professional opinion of her?

A. I have.

Q. Have you formed a personal opinion of what kind of --

A. I have.

Q. * * * how would you describe her, professionally and personally, to somebody who had never met her?

A. Professionally, I feel like she's a good doctor. She is very caring. She's a very big patient advocate, very solicitous of the care of her patients, and wants to see that they get the proper care by the staff taking care of them.

Q. And as a person, how would you describe her?

A. A nice lady.

Q. And have you noticed her to act, under stressful situations, any differently from other doctors?

A. No. I mean, I've seen other doctors act stressful, but * * * I've never really seen her, as I have seen some other physicians, become -- like, temper tantrums. I've not

[p.101]

observed that on her part.

Q. You've never seen her raise her voice at the staff in stressful situations?

A. No, I have not.

Q. Treat staff in a sort of derogatory, demeaning manner?

A. No, I have not.

Q. Have you seen her act in any other way inappropriately under stressful situations?

A. Nope. * * *

* * *

Q. * * * do you have some idea of how her patients do postoperatively, after delivery?

[p.102]

A. I think they do very well. She's very solicitous of their care. She's one of the few physicians, I think, that I've seen at Good Sam -- and I have had a history of 20 years here, working ER and ICU -- she comes in and sits down with her patients, actually in the room, and talks with them, sees how things are going. She follows through.

If there's a question or a concern the staff has about her patients, I've always felt very comfortable coming to her * * *

And she'll give me her rationale and then make a decision about what we should do. * * *

Q. Have you ever heard any nurse say they didn't want to work with her?

A. No, I have not.

Q. Do you enjoy working with her?

A. Yes, I do.

Q. Have you ever told anybody you didn't want to work with her?

A. Never.

* * *

[p.103] * * *

Q. Have you ever heard a patient complain about her?

A. No, I have not.

* * *

Q. Have you ever known her to miss a delivery?

A. No.

Q. Have you known doctors to miss a delivery?

A. Well, of course. You know, timing if of the essence for the delivery.

Q. Right. But not her?

[p.104]

A. No, not to my knowledge.

Q. Have you ever known Dr. Cowell to do anything that you considered was in any way detrimental to the health or safety of patients?

A. No. * * *

DEPOSITION UPON ORAL EXAMINATION OF MAUREEN GUZMAN

Taken Friday, May 30, 2008

* * *

[p.89] * * *

Q. I have a two-part question. First of all, during the time that you were at Good Samaritan Hospital, did you ever hear anybody raise, on any committee, any suggestion that Dr. Cowell lacked integrity?

A. No.

Q. Did you ever hear anybody in any committee suggest that she was not honest?

A. No.

Q. Did you hear anybody in any committee, or, indeed, outside of a committee, somebody like Dr. Mott or Dr. Morris, ever raise any questions about Dr. Cowell's cooperation with the peer-review process?

A. No.

Q. Did you hear anybody ever say, in response to a letter

[p.90]

that she may have written to questions about her cases, that she was combative?

A. No.

Q. Was there any meeting that Dr. Cowell was called to--peer review * * * that she didn't attend when she could have attended, that you can remember?

A. No.

* * *

[p.91]

Q. * * * Could you tell us, was Good Samaritan Hospital ever cited for using inappropriate range orders, that you're aware of?

A. Yes.

* * *

[p.92] * * *

Q. So somebody in Administration at Good Samaritan Hospital produced a falsified document in connection with a JCAHO survey; is that correct?

[p.93]

A. That's correct.

Q. * * *

Did you hear anyone ever say, in any committee, that Dr. Cowell had exceeded the scope of her privileges?

A. No.

Q. Was ever any determination made, while you were there, in connection with her reapplication for privileges, that Dr. Cowell had practiced outside the scope of her privileges?

A. No.

Q. Do you know of any incident where a finding was made, about any other physician, that they had practiced outside the scope of their privileges at Good Samaritan Hospital?

A. Yes.

Q. And do you have a knowledge of what action was taken on that finding?

A. Yes.

Q. What action was taken?

A. The chief medical officer spoke to the physician privately, and there was no formal action taken.

Q. In your experience, do you ever know of a physician who has had all their privileges revoked on an allegation that they had practiced outside the scope of their privileges without there ever having been any warning or notice that they had,

[p.94]

in fact, exceeded the scope of their privileges?

A. No.

Q. Have you ever known anybody, ever, under any circumstances, who had their privileges revoked for practicing outside the scope of their privileges?

A. No.

* * *

[p.98] * * *

Q. Have you ever known a case where, having been graded like that and sort of a final determination made, where the case is reviewed again and again and again?

A. Yes.

Q. You have?

A. Yes, I have.

[p.99]

Q. And what would be the reason for that?

A. When I noticed this happen was when Dr. Cowell's cases were reviewed multiple times.

Q. * * * I mean, forget Dr. Cowell. Is that normal practice?

A. No.

Q. Have you ever seen that happen with anybody but Dr. Cowell?

A. No.

Q. Have you seen it happen with Dr. Cowell?

A. Yes.

* * *

[p.100]

A. So your question was whether cases were reviewed a second time?

Q. Yes.

A. Yes.

Q. Can you confirm that these are the same cases that were reviewed in the previous exhibit we saw?

A. (Witness peruses document.) Yes, because this was the next meeting, and the note is, "Please see the minutes for that discussion." They would have been attached to this agenda.

Q. Okay. Do you know if these cases were ever sent out to, now, an external reviewer?

A. Yes.

Q. And then, were these cases reviewed yet again by the PRC in August of 16 (sic), those three cases?

A. Yes. They were reviewed again--

* * *

A. --by the PRC.

Q. * * * Have you ever seen anything like that before?

A. I have not.

Q. Are there any other ways that you can think of, if any, in which Dr. Cowell was treated differently from other people, in the peer-review process at GSH?

A. Yes.

[p.105] * * *

Q. --when the five cases that were sent out, of Dr. Cowell's, to an outside reviewer, he actually recommended reviewing the OB unit by ACOG? Do you recall that?

A. Yes.

Q. Were data collected in preparation for a review?

A. Yes.

Q. Did you have any involvement in that?

A. Yes. I and my department had a lot to do with the information that was collected. We were asked to collect quality data, performance data, information about the individuals practicing in the OB unit, OBs and family practitioners that were doing deliveries. We did quality data on surgeries that were performed. We put together quite a packet of information.

Q. * * * did that give you an opportunity to see where Dr. Cowell was with

[p.106]

respect to these outcome variables?

A. Yes.

Q. And where was she?

A. Pretty much right in the middle.

Q. Were there any individuals at GSH who were outliers?

A. Yes.

Q. And just for the record, what is an outlier?

A. An outlier would be a performance indicator that varies significantly from the mean; perhaps two standard deviations from the mean.

Q. Okay. Was Dr. Cowell ever an outlier with respect to any quality measure like that?

A. No.

* * *

STATE OF WASHINGTON
PIERCE COUNTY

AFFIDAVIT MAUREEN GUZMAN, R.N.

[June 6, 2008]

* * *

2. I am a Washington state Registered Nurse with a Bachelor's degree in Business Administration and Master's degree in Healthcare Administration. My Master's thesis is titled "Changing Culture In One Rural Healthcare Organization to a Culture of Patient Safety." I am certified in Quality Management from Learning Tree University and am a Certified Profession in Healthcare Quality (CPHQ). I am a past member of the Washington Health Foundation Quality Advisory Team, and the Washington Patient Safety Coalition Foundation for Health Care Quality. I am also a past member of the National Association of Medical Staff Services (NAAMS). I was employed as Director of Quality Management and Medical Staff Services at Good Samaritan Hospital from April 2003 to October 2005.

3. Since my deposition in this case on May 30, 2008, I have been provided with a copy of the affidavit executed by Dr. Jay Michaelson. Based on the description of Dr. Michaelson's involvement in the four laparoscopically assisted vaginal hysterectomies, Dr. Cowell would not have exceeded the scope of her privileges by performing the four laparoscopically assisted vaginal hysterectomy procedures referred to in his affidavit.

4. The nurses in the Good Samaritan Hospital operating room have a list of the privileges each surgeon has. The operating room personnel ask the surgeon who the assistant is when the surgeon schedules the procedure with the operating room. If normal operating procedures were followed in the four laparoscopically assisted vaginal hysterectomies referred to in Dr. Michaelson's affidavit, the nurses would have known that he was the assistant in the case and that he had privileges to perform laparoscopically assisted vaginal hysterectomies.

5. I can state that after reading Dr. Michaelson's affidavit and considering the issue of privileges further, I clearly remember that Dr. Donald Mott performed an operation on a patient's knee with another orthopedic surgeon long after Dr. Mott ceased to have surgery privileges at Good Samaritan Hospital.

FURTHER AFFIANT SAYETH NOT.

/s/ Maureen Guzman
Maureen Guzman, R.N.

Signed before me on this

6 day of June, 2008.

[Notary Seal]

Notary Public. /s/ Cynthia J. Brown
Cynthia J. Brown

STATE OF WASHINGTON
PIERCE COUNTY

AFFIDAVIT OF J. MICHAELSON, Jr., M.D.

[June 9, 2008]

* * *

2. Dr. Pamela Cowell asked me to "assist"/"mentor" her with the four laparoscopically assisted vaginal hysterectomies the operative reports of which are attachedhereto as Exhibits 1-4. Dr. Cowell offered to allow me to bill as the surgeon for these cases, given the level of my involvement, but I did not feel comfortable doing that given that I did not see the patients or work them up preoperatively, and I was not going to be looking after them post-operatively.

3. During each of these procedures, I did my side of the case, and supervised Dr. Cowell while she did her side of the case. In my role as "mentor" I supervised and took full responsibility for both sides. The extent of what Dr. Cowell actually did laparoscopically was under my direct supervision and although I have no specific memory of whether I divided the uterine arteries on one or both sides, where these were divided laparoscopically, I, as "mentor" took full responsibility for the division of both sides.

4. To call my participation in these cases as an A assistant@ in the sense that one would apply this term to a certified registered nurse first assistant (CRNFA) would be a misnomer. Dr. Cowell made it clear to me that she was looking to me to supervise her doing these cases, and had she done anything I thought was

inappropriate or that would have endangered patients, I would have intervened without hesitation. And I believe Dr. Cowell would have expected me to intervene. Thus, the patients were at no greater risk during these procedures than they would have been at risk had they been my patients, and I was performing the operations with an assistant.

FURTHER AFFIANT SAYETH NOT.

/s/ J. Michaelson Jr.
J. MICHAELSON, Jr., M.D.

Signed before me on this

9th day of June, 2008.

[Notary Seal]

Notary Public.
/s/ Wanda Davis

DEPOSITION UPON ORAL EXAMINATION OF RONALD MORRIS, M.D.

[May 29, 2008]

* * *

[p.10] * * *

Q. * * * You see the range order there for fentanyl?

A. Yes, I do.

Q. Is that an approved range order?

[p.11]

A. Approved by whom?

Q. Well, would that meet JCAHO requirements, assuming that there is no --

A. No. * * *

* * *

* * * I've never had any responsibility related to the surgery center --

* * *

But to answer your question, this order lacks the appropriate indications for the range usage.

* * *

[p.26]

Q. * * * I understand that you didn't agree with everything she said, but she cooperated, didn't she?

A. Yes, she did.

* * *

COLLEEN O'BRIEN,

[November 12, 2007]

sworn as a witness by the Notary Public,
testified as follows:

[p.4]

EXAMINATION

BY MR. KADAR:

Q. * * *

* * * were you monitoring Dr. Cowell in 2006, or her work?

A. At what point in 2006?

Q. From January onwards.

A. Yes.

Q. What were you monitoring?

A. Laparoscopic procedures.

Q. Okay. And what were you monitoring about the

[p.5]

laparoscopic procedures?

A. In 2006, with the exception of lap tubals and diagnostic laps, which she could do unassisted, she had to have a proctor and had to videotape.

Q. Okay. And is there any that she should have done that she didn't?

A. No, in 2006.

* * *

[p.6] * * *

Q. * * * If I'm a surgeon at GSH and I'm granted a list of privileges, does your office notify the operating room of what those privileges are?

A. Yes.

* * *

[p.22] * * *

Q. Now, when the cases are evaluated, however, there are three categories, aren't there? There is room for improvement, not acceptable, and sort of okay, whatever the word is, right?

A. Correct.

Q. So in your office, when you filled this out, the two categories room for improvement and not acceptable are collapsed into one category, standard not met; is that correct?

A. Correct.

* * *

[p.23] * * *

Q. * * * And the refer to attached procedure report is the procedures that I have done in the last two years?

A. Correct.

[p.40] * * *

Q. Okay. Can you turn to Exhibit 6 now, and did you type that?

A. Yes.

Q. And where were -- where did you get the script in the box?

A. This is all information that's in her quality file or her credentials file.

Q. And you did this when?

A. Before they met.

Q. * * * And did you give this to them when they met?

A. Yes.

* * *

DEPOSITION UPON ORAL EXAMINATION OF DON RUSSELL, M.D.

[March 25, 2008]

* * *

[p.12] * * *

Q. Did you know that the hearing panel found that all the factual allegations about her clinical practice had no substantial factual basis?

A. No.

Q. Do you think that's something that the MEC should have been informed about?

A. If it had no factual basis, yes, I think that's something.

Q. * * * you all in good faith, received a report.

A. Yes.

Q. And you assumed that the factual statements in that report were true.

A. Yes.

Q. And you made a decision in your best judgment assuming that those facts were true.

A. Yes.

Q. Now, if those facts are not true, would you have cast the same vote?

A. We're talking about the one case?

Q. No, I'm talking about everything related to

[p.13]

her medical care * * *

Q. * * * I don't know how much you recall. None of the factual allegations about the two cases that triggered the investigation, none of the factual allegations about the Jehovah's Witness case, and all the past cases, the committee determined there's no evidence that she ever breached accepted standards of care, no evidence that she couldn't recognize the seriousness of a patient's condition, no evidence that her behavior was inappropriate, erratic or labile. None of that had a substantial factual basis. If that was the finding, if they found that, would you cast your vote the same way?

A. No.

* * *

DARNICE SABO

[March 24, 2008]

sworn as a witness by the Notary Public,
testified as follows:

* * *

[p.7] * * *

Q. Okay. Now, how long have you worked at GSH, Ms. Sabo?

A. 16 and a half years.

Q. So you've worked with Dr. Cowell the entire time she was there?

A. Oh, yes.

Q. How would you describe your working

[p.8]

relationship with her?

A. Good.

Q. Good. Did you enjoy working with her?

A. Yes, I did.

* * *

Q. * * * do you have an opinion as to what kind of a professional she is, in terms of does she care for her patients and the people she works with?

A. She does care for her patients, and I think she does care for the people she works with.

Q. Did you ever tell anybody you didn't want to work with her?

A. No, I did not.

Q. * * * you didn't have any complaints about working with her.

A. No, I did not.

* * *

STATE OF PENNSYLVANIA
ALLEGHENY COUNTY

AFFIDAVIT of
JOSEPH S. SANFILIPPO, MD, MBA

[June 10, 2008]

* * *

1. Scope of privileges: Dr. Cowell was granted privileges to perform vaginal hysterectomy, abdominal hysterectomy, salpingectomy as well as minimally invasive surgical procedures such as diagnostic laparoscopy and laparoscopic tubal sterilization. She managed four (4) patients for laparoscopic assisted vaginal hysterectomy (LAVH) with Dr. Michaelson serving as proctor. Dr. Cowell was certainly within the scope of her privileges performing LAVHs with an individual credentialed for this procedure, i.e. Dr. J. Michaelson, Jr. In reviewing Dr. Michaelson's affidavit he attests to the patients being operated upon by Drs. Michaelson and Cowell being at no greater risk than if they been his patients exclusively.

* * *

In summary, my opinion focuses on the fact that the peer review process provided for Dr. Cowell, resulting in suspension of privileges at Good Samaritan Hospital and reporting of such to the National Data Bank did not take into account her provision of patient management that indeed met the standard of care. Appropriate supervision was sought and complied with regarding her privilege status, i.e. LAVH surgical procedures. I have served as President of the medical

staff at a large university affiliated hospital and was required to deal with the peer review process on an ongoing basis. Specifically if the mode of practice that Dr. Cowell provided were reviewed I would state in all probability she would not have had her privileges revoked. I reserve the right to supplement or revise my opinions based upon additional information I receive.

FURTHER AFFIANT SAYETH NOT.

/s/ Joseph S. Sanfilippo, MD
Joseph S. Sanfilippo, MD, MBA

Signed before me on this
10th Day of June, 2008.

/s/ Dale A. Daley
Notary

[Notary Seal]

MAUREEN SMITH, M.D.,

[November 12, 2007]

sworn as a witness by the Notary Public,
testified as follows:

* * *

[p.18] * * *

Q. Okay. Let me just establish, you reviewed Exhibit 2, correct, which is the request for corrective action against Dr. Cowell from Snodgrass, you reviewed that?

A. I do not remember seeing this piece before

* * *

[p.38] * * *

Q. Okay. These nine cases in which the standard of care was not met, do you know anything about those cases other than the ectopic case which you indicated in your reply that you remember, the one that you --

A. We had read the one Dr. Cowell thing at one point, but we did not go back and review the cases.

Q. Now when you say review the cases, you didn't review the medical records?

A. Yes.

* * *

[p.41] * * *

Q. Okay. Do you know if the nine cases in which the standard of care not met, any of them had any adverse outcome related to Dr. Cowell's management?

A. I don't believe they did, if you meant adverse by death.

Q. I don't mean dead * * * do you know if they had any significant complications or adverse events or adverse outcome?

A. I did not review those cases.

Q. So you don't know?

A. Correct.

Q. You reviewed Dr. Cowell's privileges in the past, what she had privileges to do.

A. I did not review the individual privileges that -- the check box forms that come.

* * *

[p.42] * * *

Q. Now, were you able to determine from whatever it is that you reviewed through your investigation, what specific behavior was characterized as erratic, labile or inappropriate?

A. No, not myself.

Q. Okay. Do you recall any cases, the specifics of any cases, in which her behavior was described as erratic, labile or inappropriate?

A. No.

* * *

[p.43] * * *

Q. Well, you don't know whether whatever they were referring to and describing as erratic, inappropriate or labile, whether you would have characterized it as erratic?

A. Correct. Another entity described it.

Q. And therefore, you don't know whether that other person describing it, that description was sort of accurate or an appropriate description?

A. Correct. I did not see it.

* * *

[p.46] * * *

Q. Did you read Exhibit 8, which for the record is a letter to Dr. Kornberg from Dr. Cowell dated August 3, 2000?

A. I can't recall.

Q. Were you aware that Dr. Cowell attempted to video one of her cases but the nurse couldn't work the equipment, were you aware of that?

A. No.

* * *

[p.47] * * *

Q. Did you have an understanding of why Dr. Cowell could not apply for those procedures then, meaning January the 5th, 2001, but could apply for them at a later date?

A. No.

* * *

[p.48] * * *

Q. Did you ever know --

A. Why she couldn't then, no.

Q. Did you make an attempt to find out?

A. Why she couldn't apply in January of 2001? No.

Q. * * * But why is it that she could apply at a later date for the same procedures that she couldn't apply for in 2001, or what it is that she had to fulfill to qualify? Did you ever try and find that out?

A. No.

Q. Would you agree with me it's not clear from this letter?

A. It is not clear in that letter.

* * *

[p.49] * * *

Q. Okay. Do you have privileges to do, let's say, intubations?

A. Do what?

Q. Intubations?

A. Yes.

Q. Supposing I was a physician on the staff at GSH and I didn't have privileges to do intubation, could I do one with you there, show me how?

MR. MONTGOMERY: Objection, no foundation. You can answer if you can.

A. Yes, I believe you could.

* * *

[p.66] * * *

Q. Do you know that the external reviewer said, was, quote, very troubled by the nurse's conduct, were you aware of that?

[p.67]

A. I do not recall hearing that.

* * *

DEPOSITION UPON ORAL EXAMINATION OF CECIL SNODGRASS, M.D.

[November 13, 2007]

* * *

[p.39] * * *

Q. So your request for corrective action had nothing to do with the fact that in 2003 she declined counseling, had it?

A. No, sir.

Q. And your request for corrective action had nothing to do with that she didn't videotape some laparoscopic procedures, did it?

A. I didn't have that knowledge at the time. However, if I had that knowledge it certainly would have played into this, but no, sir, it did not.

Q. It wasn't based on --

A. No, sir, it was not.

Q. And your request wasn't based on the allegation that she had exceeded the scope of her privileges, was it now?

A. No, sir.

* * *

[p.95] * * *

Q. * * * Doctor, though, these two cases were presented to two different hearing panels. Are you aware of that?

A. Yes, sir.

Q. Do you know what the findings of the hearing panels were?

[p.96]

A. I would have to review those to give you a complete answer.

* * *

Q. Were the hearing panel reports ever presented to the MEC?

A. I believe a summary of their reports were.

Q. But not the actual report?

A. I can't tell you. I don't have a recollection of everything two years ago, sir.

Q. But you would know. Wouldn't you remember if your allegations that you made about two cases, two different hearing panels found that there was no substantial factual basis for them? You would remember something like that, wouldn't you, Doctor, if it was ever presented to you?

A. Well, I believe I would, but I don't believe that was the case.

Q. You don't believe the two hearing panels found

[p.97]

that?

A. I don't believe so.

* * *

DEPOSITION UPON ORAL EXAMINATION OF KEVIN TAGGART

[May 29, 2008]

* * *

[p.26] * * *

Q. Okay. How long would you estimate it took you to review the first two cases -- the medical records; that's to say, the abscess case and the placenta case?

A. Oh, I think I spent an hour, hour and a half --

* * *

[p.44] * * *

Q. Did you come across any QMM, minutes of any meeting, any evidence that any nonlaparoscopic surgical case that Dr. Cowell had done at Good Samaritan Hospital over the preceding eight years was deemed to have been deficient in some way?

A. No.

Q. Now, during your meetings with Dr. Cowell, if I recall correctly, the July 13th, the second meeting was solely about the Jehovah's Witness case, correct?

A. Correct.

Q. So during the first meeting in June, did you question Dr. Cowell about any of her past cases; that's

to say, in any other case, except the abscess and placenta cases?

A. I believe we didn't.

* * *

[p.79] * * *

Q. * * * Had anybody ever, in any document that you reviewed, voiced concerns about Dr. Cowell's open surgery?

A. You asked me that before, and the answer was no.

* * *

[p.80] * * *

Q. * * * I've just stapled together the four --

* * *

-- operative reports.

First of all, did you review those?

A. I don't believe I reviewed all of them.

Q. * * * -- well, all right.

Did you have any understanding of the circumstances under which Dr. Cowell came to do these cases?

A. No.

* * *

[p.81] * * *

Q. And you did not come across, did you, any document, peer review, letters, or anything from anybody suggesting that Dr. Cowell had -- telling her that she had exceeded the scope of her privileges, correct?

A. Correct.

* * *

STATE OF WASHINGTON
COUNTY OF PIECE

Statement of Dawn Wadleigh, LM, CPM

[November 15, 2006]

* * *

2. I am a licensed midwife and certified professional midwife. I have known Dr. Pamela Cowell for the past four years. During this time I have called Dr. Cowell for consultation for many of my patients.

3. * * * Dr. Cowell is obviously a skilled surgeon, was professional as well as very kind to my patients.

4. What my patients especially appreciate about Dr. Cowell is her thorough explanations and her willingness to allow the patient and her family to participate in decision making. Many times she will wait patiently in the wings while the family takes time to consider their options, discussing it again with Dr. Cowell and coming together to make a final decision. This approach has resulted in many happy patients and families, making sense medically as well as emotionally.

5. All the outcomes have been good and all the patient feedback positive.

6. I hear the same reports from the other midwives in our community. Dr. Cowell is a valuable resource for us and we do not hesitate to bring our patients to her at Good Samaritan Hospital with confidence.

7. Dr. Cowell works well with the nursing staff in the Family Birth Center. I have noted that she has a cordial and respectful relationship with the nurses and other doctors and staff and that they all appear to genuinely enjoy working with her.

8. Although I always call her at the worst times * * * she is always gracious and eager to help me and my patients at any time. She will stay late in the office to accommodate us or she will gladly come to the hospital at 3 am to consult for my laboring patient.

* * *

/s/ Dawn Wadleigh, LM, CPM
Dawn Wadleigh, LM, CPM

Signed before me on this 15 day of November, 2006.

/s/_____
Notary Public.

[Notary Seal]

DEPOSITION UPON ORAL EXAMINATION OF MICHELLE WATERLAND

[May 29, 2008]

* * *

[p.22] * * *

Q. * * * -- you know that the Jehovah's Witness patient had a form like that made out by Dr. Rinker, do you?

A. Yes.

Q. Okay. Now, did you give the fentanyl pursuant to this order?

A. Yes.

Q. * * * -- that order doesn't indicate how quickly you can give the fentanyl, does it?

A. This order does not.

* * *

[p.25] * * *

Q. * * * you gave 200 milligrams -- micrograms -- * * * in ten minutes, didn't you?

A. Correct.

Q. And you didn't feel that that was an excessive rate of administration?

A. Correct.

Q. How about if you'd given it in eight minutes, would that have been excessive?

A. No.

* * *

DEPOSITION UPON ORAL EXAMINATION OF ROBERT WRIGHT, M.D.

[November 14, 2007]

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[p.31] * * *

Q. * * * -- next exhibit, Exhibit 8, did you

[p.32]

review Dr. Cowell's letter of August the 3rd, 2000 to Dr. Kornberg?

A. I don't remember seeing this document.

Q. Were you aware that at least she attempted to videotape one procedure and apparently was unable to -- somebody was unable to work the equipment or whatever? Were you aware of that?

A. Nope.

Q. Could you go to Exhibit 9. Have you read that letter?

* * *

A. I don't remember seeing this document, no.

* * *

[p.50] * * *

A. I actually didn't know that the terbutaline and the umbilical cord were the same case, to be honest with you.

* * *

[p.59] * * *

A. True. True, I agree there was no concern regarding her open cases.

Q. Okay. * * * Exhibit 22, first question again, have you seen it? Did you review that?

A. No, I haven't seen this review. This is a synopsis. Is this a synopsis, is that what this is?

Q. No, this is the protocol according to which the focused review was going to be conducted, and at the end of Page 3 is the questions, the predetermined

[p.60]

questions, I mean, I just --

A. I have not seen this document.

Q. Did you know how the focused review was conducted?

A. No.

Q. Okay. Did you know that it said Theresa Young to assure that all the procedures are videotaped, Theresa Young was put in charge of that?

A. Nope. I knew that they were supposed to be videotaped, but.

Q. Okay. Did you know what the results of the focused review was?

A. Not offhand.

* * *

[p.65] * * *

Q. * * * Just the external reviewer of the past -- the five cases that were sent out, you didn't read that review?

A. I don't recall reading that, no.

* * *

[p.82] * * *

Q. * * * look at Exhibit 41. * * * -- Following a lengthy discussion committee members expressed concern that there appeared

[p.83]

to be a lack of insight or recognition of the issues for any of the cases reviewed.

* * * when you read a comment like that, you're assuming that that's true, by which I mean not that that is a valid opinion, but that opinion is based on factually correct -- correct facts?

A. Yes.

Q. Okay. So you didn't -- and you're assuming that indeed that the PRC themselves reviewed the facts as opposed to have somebody present the facts to them?

A. I presumed that what had been done before us was reliable.

Q. Fine. And what was the point of you going through all that? This is what I can't get.

A. That was -- the point was we needed somehow to know what had been done.

Q. Why did you have to know that?

A. I don't know. It was part of our mandate, apparently. I don't know why, but that apparently was part of our mandate.

* * *

[p.102]

explaining all of the ramifications of the bylaws in the conduct of our investigation, no. Nobody sat down with us and said this you may do, this you may not do. We were sort of on our own to investigate, and we asked Colleen for things and she gave us things, and --

Q. * * * You didn't know she actually videotaped the two procedures.

A. No.

* * *

[p.109] * * *

Q. By the way, did you review what you didn't realize was a request for a corrective action, but you reviewed that letter from Snodgrass to Lambert, yes?

A. No.

* * *

DEPOSITION UPON ORAL EXAMINATION OF STEVEN YAMAMOTO, D.O.

[March 25, 2008]

* * *

[p.17] * * *

Q. * * * You don't say limited scope of laparoscopic surgical procedures. This could be read, if somebody didn't know anything about the case, that she had limited surgical procedures. Now, that's not true, is it?

A. No, sir.

Q. Okay, that's just -- I want to clarify that. So you were aware that she had the full range of nonlaparoscopic surgical procedures --

A. Yes, sir.

Q. -- so she could do vaginal hysterectomies, abdominal hysterectomies, yes?

A. Yes, sir.

Q. Repair cystoceles, yes?

A. Yes.

* * *

[p.22] * * *

Q. So if anybody misrepresented that you had determined, and that it was in the record, that the laparoscopic component of what she did was * * * significantly more complex than the procedures for she had privileges, you never made any such finding, did you?

A. No. Our job was not to make the determination in terms of complexity, it was to determine whether she was credentialed or not.

Q. * * * Dr. Snodgrass didn't testify at the hearing, did he?

A. No, sir.

* * *

[p.23] * * *

Q. * * * And there were multiple minutes of OB committee meetings, peer review committee meetings and medical executive committees in that record, right?

A. Correct.

Q. Okay. And it is the case, isn't it, Dr. Yamamoto, that not a single one of those minutes indicate that anyone at any time had ever alleged that Dr. Cowell failed to cooperate with the peer review process? That's true, isn't it?

A. It was not blatantly portrayed as such, no.

* * *

[p.24] * * *

Q. And none of those minutes make any allegation that she had exceeded the scope of her privileges, does it? There's nothing in the -- there's no document making that allegation before the investigating committee made that allegation, is there?

A. Don't' recall seeing any of that information.

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TRANSCRIPT OF THE CONFIDENTIAL HEARING OF PHYSICIAN 1189

JEAN HORNER

[November 19, 2006]

[p.148] * * *

CROSS-EXAMINATION

* * *

Q. Good evening, Ms. Horner. My name is Nicholas Kadar, and I represent Dr. Cowell. You were questioned about this case by Department of Health inspectors. Do you recall that?

A. I believe so.

Q. And you told the Department -- * * *

[p.149]

* * * -- DOH inspectors that, quote -- * * * that Dr. Cowell was one of the nicest persons you had ever met; isn't that true?

A. Yes, it is.

Q. Do you stand by that statement?

A. Yes, I -- I do.

* * *